

Minnesota Attorney General: Administrative Rules Proceedings

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SF-00006-05 (4/86)

DEPARTMENT : ATTORNEY GENERAL

STATE OF MINNESOTA

Office Memorandum

DATE : December 12, 1989

TO : JOHN A. BREVIU
Assistant Attorney General
525 Park Street, Suite 500 (55103)

FROM : MARTHA J. CASSERLY
Special Assistant Attorney General
525 Park Street, Suite 404 (55103)

PHONE : 296-6839

SUBJECT : In the Matter of the Adopted Permanent Rule Relating to Fee-Splitting

The above-referenced Permanent rule has been approved as to its legality by the Attorney General on December 12, 1989.

Enclosed is your copy of the approved rule. This office has already filed two copies with the Secretary of State, who will forward one copy to the Revisor of Statutes. The fourth is being retained by this division of the Attorney General's Office for its records.

Also enclosed are any petitions, requests, submissions or comments along with any extra copies of documents which you submitted to the Attorney General.

Your next step is to arrange for publication of the Notice of Adoption in the State Register. In a day or two, you should receive from the Revisor's Office three copies of the notice of adoption of your rule. You should submit two copies of the Notice of Adoption to the State Register for publication. A permanent rule without a hearing does not become effective until five days after a notice of adoption is published in the State Register in accordance with Minn. Stat. { 14.27. An emergency rule becomes effective five working days after approval by the Attorney General; however, the agency must publish a notice in the State Register in accordance with Minn. Stat. { 14.34.

If you have any questions in this regard please contact me.

MJC:bbl
Enclosures
cc: William Brown, Chief Judge (memo only)
MaryAnn Hruby " "

Board of Medical Examiners

Adopted Permanent Rules Relating to Fee Splitting

Rules as Adopted

5620.0100 PURPOSE.

The purpose of Minnesota Statutes, section 147.091, subdivision 1, paragraph (p), and parts 5620.0110 to 5620.0160 is to protect consumers against medical-economic arrangements, practices, and relationships by physicians that unnecessarily increase the cost of health care to consumers, restrict consumer access to goods and services, and otherwise present harm to consumer interests. The board shall comply with Minnesota Statutes, section 147.091, subdivision 1, paragraph (p), and parts 5620.0110 to 5620.0160 in evaluating complaints received by the board relating to medical-economic arrangements, practices, or relationships among health care providers.

5620.0110 DEFINITIONS.

Subpart 1. **Scope.** As used in Minnesota Statutes, section 147.091, subdivision 1, paragraph (p), the following terms have the meanings given them.

Subp. 2. **Device.** "Device" means an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article including a component, part, or accessory, that as a completely assembled article exceeds $99 in cost and is:

A. recognized in the official United States Pharmacopoeia and National Formulary and its supplements;

B. intended for use in diagnosing disease or other conditions, or in curing, mitigating, treating, or preventing disease in a person;

C. intended to affect the structure or function of the body of a person, and that does not achieve any of its principal intended purposes through chemical action within or on the body of a person and is not dependent upon being metabolized

for the achievement of any of its principal intended purposes; or

D. restricted under federal law to sale by or on the order of a licensed practitioner.

Nondurable medical equipment, meaning a supply or piece of equipment that is used to treat a health condition and cannot be reused, is excluded from this definition of device.

Subp. 3. **Drugs.** "Drugs" has the meaning in part 5600.0100, subpart 8.

Subp. 4. **Financial interest.** "Financial interest" means an asset that is directly owned or controlled by an individual or business and that has the potential to produce a monetary return.

Financial interest does not include the ownership of a building by a physician where space is leased to an individual or organization at the prevailing rate in a straight lease agreement or any interest held by a physician in a publicly traded stock.

Subp. 5. **Profit interest.** "Profit interest" means a financial amount received by the physician that exceeds the acquisition cost of a drug or device plus the cost of having the drug or device available.

Subp. 6. **Significant financial interest.** "Significant financial interest" means any financial interest as defined in subpart 4 that is equal to or greater than five percent of the whole or $5,000, whichever is the lesser amount.

5620.0120 INCORPORATION BY REFERENCE OF CRITERIA TO DEFINE DEVICE.

The most recent edition of the United States Pharmacopoeia and National Formulary and its supplements are incorporated by reference. The publication is issued by the United States Pharmacopeial Convention, Inc., 12601 Twinbrook Parkway, Rockville, Maryland, 20852. It is available for inspection and copying through the Minitex interlibrary loan system. The publication is subject to change.

5620.0130 DISCLOSURE REQUIREMENTS AND FORMATS.

Subpart 1. **Written disclosure required.** The disclosure requirements in Minnesota Statutes, section 147.091, subdivision 1, paragraph (p), are met if the written disclosure is made before a referral. The written disclosure must reasonably apprise the patient or patient's guardian of the physician's financial and profit interest in the individual or entity to which the physician is making the referral, and contain a statement that the patient is free to choose providers other than the one recommended by the physician. The written disclosure must consist of one of the formats in items A to D.

A. The posting of a conspicuous sign in an area that is likely to be seen by the patients and patients' guardians who use the physician's facility.

B. The incorporation of a conspicuous written notice in existing office documents used by the physician. Office documents may include, but are not limited to, prescription sheets, office information or policy booklets, referral forms, and any similar regularly distributed information handout.

C. The use of a written disclosure document that is given to a patient or patient's guardian for review. A copy of the document must be provided to the patient or patient's guardian.

D. A combination of the written disclosure formats described in items A to C.

Subp. 2. **Unwritten disclosure; when allowed.** A nonwritten disclosure format may be used to satisfy the disclosure requirements of Minnesota Statutes, section 147.091, subdivision 1, paragraph (p), when necessary to accommodate the physical condition of a patient or the patient's guardian that makes use of written disclosure alone unworkable.

Subp. 3. **Information must be updated.** The disclosure information shall be updated to show any change in the circumstances regarding the physician's financial or profit interest.

5620.0140 EVIDENCE OF DISCLOSURE.

When the board investigates a violation of Minnesota Statutes, section 147.091, subdivision 1, paragraph (p), the burden of proof is on the physician investigated to show evidence the physician complied with disclosure requirements in part 5620.0130.

5620.0150 DISCLOSURE OF PROPRIETARY INFORMATION.

Specific contract terms or similar proprietary information relating to a physician's financial and profit interest is not required to be part of the information provided in a disclosure under part 5620.0130.

5620.0160 DIVISION OF FEES.

In reviewing a division of fees as described in Minnesota Statutes, section 147.091, subdivision 1, paragraph (p), clause (2), the board may consider, but is not limited to, the following factors regarding the reasonableness of a proportional division of fees:

A. the value of professional services;

B. overhead costs;

C. time and distance traveled; and

D. the availability of the service or product elsewhere in the local trade area.

RECEIVED
OCT 19 1989
Office of the Attorney General
Government Services Section
Capitol Office Bldg. - Suite 500
525 Park Street
St. Paul, MN 55103

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED

DEC 12 1989

Joan Anderson Growe

Secretary of State

11:40 AM

APPROVED AS TO FORM AND LEGALITY

December 12 1989

HUBERT H. HUMPHREY, III
ATTORNEY GENERAL

BY M J Cassely

SPECIAL ASSISTANT ATTORNEY GENERAL

RECEIVED

OCT 19 1989

Office of the Attorney General
Government Services Section
Capitol Office Bldg., Suite 500
525 Park Street
St. Paul, MN 55103

MJC X

RULE REVIEW CHECKLIST

File No. 1644 — Docket No. 05 0009 0480

DATE RECEIVED 11-28-89 — ADOPTED W/O HEARING X

REVIEW DATE 12-7-89 — EMERGENCY RULE ____

DUE DATE 12-12-89 — TO REVISOR ON 12-4-89

REVISOR APPROVED ✓

APPROVED 12-12-89 MJC — REVISOR DISAPPROVED ____

DISAPPROVED ____ — FILED W/SEC. OF STATE 12-12-89

WITHDRAWN ____ — RETURNED TO AGENCY 12-12-89

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4 Rule as adopted (4 copies) not back from Revisor

✓ Notice to Solicit Outside Information/Opinion (if applicable)
July 4, 1988 Date published in State Register per Statement of Need and Reasonableness
0 Comments

~~Petition for Adoption of a Rule (if applicable)~~

✓ Board's Authorizing Resolution
July 27, 1988 Date adopted

✓ Proposed Rule
____ Revisor's Certificate

✓ Notice of Intent to Adopt Rule
147.01 sub 3 Statutory Authority
NA Small Business Statement
NA Expenditure of public money statement
4-24-89 Signature

✓ Statement of Need and Reasonableness (if applicable)
✓ Small Business Statement attorney notes problems
NA Fees - § 16A.128

____ Affidavit of Mailing Notice of Intent to Adopt Rule
July 10, 1989 Date (30)/25 days before adoption
____ Notice attached indicates notice is attached
____ Copy of rule or summary attached

✓ Publication in State Register
July 10, 1989 Date (30)/25 days before adoption

____ 180-day deadline from:
NA Effective date of law requiring rule (14.12) (both rules) not required
✓ end of comment period (§ 14.26) (rules without hearing) Aug 9 – Nov 28
____ effective date of statutory authority (§ 14.29) (emergency rules)

✓ Resolution Adopting
Sept 6, 1989 Date adopted

✓ Findings of Fact, Conclusions & Order Adopting
Sept. 16, 1989 Date

✓ Written requests, submissions or comments

✓ Declaration of attorney
John Brewer Name of SAAG representing agency — read attorney's declaration

Nov 28, 1989 Notice of Submission to Atty. Gen. (if applicable)

Nov 28, 1989 Aff. of Mailing Notice to Atty. Gen. (if applicable)

DEPARTMENT : ATTORNEY GENERAL - Health

STATE OF MINNESOTA

Office Memorandum

DATE : November 28, 1989

TO : PATRICIA NOLTE
Legal Assistant

FROM : JOHN A. BREVIU
Assistant Attorney General

PHONE : 297-5931

SUBJECT : In the Matter of Proposed Rules Governing Fee-Splitting

Enclosed for your review, pursuant to Minn. Stat. § 14.26 (1988) and Minn. Rules pt. 2010.0300 (1989), are the following documents to support the above-referenced rules:

1. Notice of Solicitation of Outside Opinion;
2. Certificate of Board's Authorizing Resolution;
3. Rules as proposed with a certificate of approval as to form by the Revisor of Statutes attached;
4. Notice of Intent to Adopt Rules Without a Public Hearing (as mailed);
5. Statement of Need and Reasonableness;
6. Affidavit of Mailing the Notice of Intent to Adopt Rules Without a Public Hearing;
7. Notice of Intent to Adopt Rules (as published in the State Register);
8. Rules as adopted (original and three copies);
9. Certificate of Board's Resolution Adopting Rules;
10. Findings of Fact, Conclusions, and Order Adopting Rules Without a Public Hearing;
11. Written requests, submissions, and comments on the rules;
12. Declaration of Counsel;
13. Notice of Submission to the Attorney General;

14. Affidavit of Mailing Notice of Submission to the Attorney General.

JAB:sv

Enclosures

STATE OF MINNESOTA
COUNTY OF RAMSEY

BEFORE THE MINNESOTA
BOARD OF MEDICAL EXAMINERS

In the Matter of Proposed
Rules Relating to Fee Splitting
By Physicians

STATEMENT OF NEED
AND REASONABLENESS

Pursuant to Minnesota Statute section 14.23 (1984), the Minnesota Board of Medical Examiners (hereinafter "Board") hereby affirmatively presents the need for and facts establishing the reasonableness of proposed rules part 5620.0100 to 5620.0160, relating to fee splitting by physicians.

In order to adopt the proposed rules, the Board must demonstrate that it has complied with all procedural and substantive requirements for rulemaking. These requirements are as follows: 1) there is statutory authority to adopt the rules; 2) the rules are needed; 3) the rules are reasonable; 4) all necessary procedural steps have been taken; 5) any additional requirements imposed by law have been satisfied. This Statement demonstrates that the Board has met these requirements.

1. STATUTORY AUTHORITY

The statutory authority of the Board to adopt these rules is as follows:

Minnesota Statute, section 147.01 (1984) authorizes the Board to promulgate rules necessary to administer Minnesota Statutes, section 147.091.

2. STATEMENT OF NEED

There are three primary reasons why regulations on fee splitting by physicians are needed. The first reason is to ensure protection of consumers against medical-economic arrangements, practices or relationships which unnecessarily increase health care costs and/or restrict consumer access to goods and services. The 1988 amendments to Minnesota Statute section 147.091, Subdivision 1, paragraph (p) and the proposed rules provide greater clarification of the scope of prohibited conduct constituting fee splitting thus delineating a clearer standard for physicians to follow.

The second reason for the fee splitting rules is to provide physicians the flexibility to structure their economic arrangements, practices or relationships so as to remain economically competitive without improperly restricting or taking unfair advantage of consumers. The 1988 amendments to Minnesota Statutes. section 147.091, subdivision 1, paragraph (p) and the proposed rules, through the use of disclosure to consumers of physician economic interests, establish permissible fee splitting arrangements, practices and relationships while still retaining the disciplinary nature of the fee splitting law.

The third reason for the fee splitting rules is to have physicians and consumers participate together in obtaining cost effective health care. By consumers being made aware of physician financial interests and the option to select other providers, consumer choice becomes the market regulator rather than Board. The Board's intervention will only occur when consumer interests are ignored, diminished through subterfuge or found secondary to the physician's financial interests. By design, the disclosure provisions intend that consumers ask questions of their physicians. With questions from consumers, physicians will become more aware of consumer needs and concerns and, to stay competitive, will adapt to those needs and concerns.

The main function of the proposed fee splitting rules is to define Minnesota Statute, section 147.091, Subdivision 1, paragraph (p), by setting forth the meaning of the economic-medical terminology used in the law and by establishing the guidelines regarding the content and the format for compliance with the disclosure provisions of the law.

3. STATEMENT OF REASONABLENESS

In 1986 the Board conducted a study of existing statutes, rules, and policy statements on fee splitting in the other 49 states, the District of Columbia, and territories with medical boards. Of 67 jurisdictions contacted, 33 responded with 23 jurisdictions sending some form of regulation or policy statement.

Legislation was proposed and Minnesota Statutes, section 147.091, subdivision 1, paragraph (p) was amended in 1988. The legislation was written in general terms which would later be clarified by the rules of the Board.

On July 4, 1988 the Board published the "Notice of Intent to Solicit Information from Non-Agency Sources." As a means to receive input from physicians across the state of Minnesota on the fee splitting law and proposed rules, the Board conducted a series of Forums on Fee Splitting throughout Minnesota.

The Forums were held in Mankato, MN at the Mankato East High School on July 13, 1988, in Duluth, MN at St. Mary's Hospital on July 18, 1988, in Detroit Lakes, MN at the Holiday Inn on July 20, 1988, in Minneapolis, MN at the Hennepin County Medical Center on July 27, 1988 and in St. Paul, MN at the Board's Conference Room on August 3, 1988. At each Forum the Board's Executive Director and selected Board members outlined the 1988 fee splitting law amendments and then requested comments and questions from the audience. A handout was provided for each

attendee. The audience members were encouraged to submit written input to the Board on the proposed rules. All the Forums were tape recorded and a list of those attending each session was made.

The Board also established a fee splitting rule mailing list for persons interested in being involved in the rulemaking process.

After the Forums, Board staff summarized the comments and questions raised during the Forums. Also correspondence sent to the Board on the proposed rules was reviewed. From this information a number of common concerns, issues, and questions arose. They include, but are not limited to the following:

1. The need for the Board to provide clarification of the operative terms of the 1988 amendments to the fee splitting law. These terms include:
   a. significant financial interest
   b. profit interest
   c. dispensing for profit
   d. drugs
   e. devices
   f. terms of division
   g. disclosure
   h. primarily for referral
2. A repeated request that the Board keep the rules simple and not unduly burdensome with paperwork, so as to not scare or confuse patient-consumers.

3. The need for the Board to clarify the extent that proprietary information would be required to be disclosed under the disclosure provisions of the law.
4. The need for the Board to describe acceptable methods or formats for compliance with the written disclosure provisions of the fee splitting law.
5. The need for the Board to indicate the degree of impact the 1988 amendments to the fee splitting law will have on joint ventures or ancillary service arrangements.

The Board utilizing this input developed these proposed rules.

FEE SPLITTING RULES

5620.0100 PURPOSE

The purpose of Minnesota Statutes, section 147.091 subdivision 1, paragraph (p) and parts 5620.0110 to 5620.0160 is to protect consumers against medical-economic arrangements, practices, and relationships by physicians that unnecessarily increase the cost of health care to consumers, restrict consumer access to goods and services, and otherwise present harm to consumer interests. The board shall comply with Minnesota Statutes, section 147.091 subdivision 1, paragraph (p), and parts 5620.0110 to 5620.0160 in evaluating complaints received by the board relating to medical-economic arrangements, practices, or relationships among health care providers.

It is reasonable and necessary that the Board state the purpose of the fee splitting law. By stating the purpose of the law, the Board identifies for physicians and the public the problems it is seeking to correct or prevent. Such clarification will assist with physicians in understanding and complying with the fee splitting law.

This provision is an acknowledgment by the board of its primary charge of protecting the public from unlawful and unprofessional actions by physicians. In order to fulfill that charge, the Board recognized that regulations were needed to act against arrangements, practices and relationships that unnecessarily increase costs of health care and restrict consumer access to goods and services. The provision is also a statement to physicians that the Board only acts based on receipt of a complaint and that it structures its review within the parameters described by Minnesota Statutes, section 147.091, subdivision 1, paragraph (p) and these proposed rules.

By providing a focus for Minnesota Statutes, section 147.091, subdivision 1, paragraph (p), this rule also serves to remind physicians of their ethical and professional responsibilities of insuring that the medical care of their patients must be their primary concern above any financial interests which they may have. (See attachment - Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association and the Minnesota Medical Association.)

5620.0110 DEFINITIONS

Subpart 1 Scope: As used in Minnesota Statutes, section 147.091, subdivision 1, paragraph (p), the following terms have the meanings given them.

The definitions in this section are necessary to discuss and understand the substantive provisions of Minnesota Statutes, section 147.091, subdivision 1, paragraph (p) and these rules. It is reasonable and necessary that physicians understand the medical and economic terminology used so they recognize if they are within the purview of the law and rules and to comply with any disclosure requirements.

Subpart 2 Device: "Device" means an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article including a component, part, or accessory, that as a completely assembled article exceeds $99 in cost and is:

A. recognized in the official National Formulary or United States Pharmacopoeia or any supplement to them;

B. intended for use in diagnosing disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease in a person;

C. intended to affect the structure or function of the body of a person, and that does not achieve any of its principal intended purposes through chemical action within or on the body of a person and is not dependent upon being metabolized for the achievement of any of its principal intended purposes; or

D. restricted under federal law to sale by or on the order of a licensed practitioner.

Nondurable medical equipment, meaning a supply or piece of equipment that is used to treat a health condition and cannot be reused, is excluded from this definition of device.

This provision is necessary to provide physicians and the public a comprehensive and clear description of what constitutes a device under Minnesota Statutes, section 147.091, subdivision 1, paragraph (p). The language of the provision is modeled after the definition of device found in the Federal Food, Drug and Cosmetic Act of 1976 Chapter I, section 321 (h), thus incorporating widely recognized terms used in describing and defining a medical device.

Using this descriptive foundation, the Board incorporated additional standards to structure a definition applicable to fee splitting situations. The additional standards involved setting a financial cost per item ($99) as a minimum level at which the Board will entertain jurisdiction of a case and the exclusion of nondurable medical equipment from the definition of device. The reason for setting the $99 minimum cost for a completed item as the standard was to recognize that the Board's intervention must

occur in situations financially significant to consumers but not of marginal financial interest to physicians. The $99 figure was considered reasonable because most consumers can afford $99 for a single purchase and because physicians are not likely to be involved in transactions with only a few items but to have sufficient quantities purchased and made available so as to generate a profit. Therefore, the physician's investment is likely to be at least in the thousands of dollars and thus financially significant.

The exclusion of nondurable medical equipment from the definition of device is necessary to avoid creating an unreasonable burden on physicians regarding the monitoring of the purchase and dispensing of single use items. By excluding nondurable medical equipment, the Board is emphasizing the standard that a physician's investment in a device must be substantial and with the purpose of seeking a profit. With the exclusion of nondurable medical equipment from the definition of device, the burden of physicians monitoring and disclosing financial interests on routinely dispensed single use items is removed.

The combination of recognized terminology, defining a medical device, the setting of specific financial standards on the cost of a device, and the exclusion of single use equipment from the definition of device provides a definition which is clear, comprehensive, and cognizant of both consumer and physician financial interests and costs.

Subpart 3: Drugs. "Drugs" has the meaning in part 5600.0100, subpart 8.

It is reasonable and necessary that the term drugs, as used in Minnesota Statutes, section 147.091, subdivision 1, paragraph (p) and these rules, be defined. By using the existing definition of drugs as found in part 5600.0100, subpart 8, the Board maintains consistency of terminology within its rules and utilizes an historically accepted definition of drugs recognized by Minnesota physicians. This rule language also provides for both brevity and clarity.

Subpart 4: Financial Interest. "Financial interest" means an asset that is directly owned or controlled by an individual or business and that has the potential to produce a monetary return.

Financial interest does not include the ownership of a building by a physician where space is leased to an individual or organization at the prevailing rate in a straight lease agreement or any interest held by a physician in a publicly traded stock.

It was essential to define the term "financial interest" to clarify for physicians what is required under the disclosure provision of Minnesota Statutes, section 147.091, subdivision 1, paragraph (p) clause (3) and to set the general standard of what interest is involved in the definition of "significant financial interest", also contained in the law. The term "financial interest" is defined broadly for two reasons. The first reason is to provide simplicity of statement when making disclosure as

required under Minnesota Statutes, section 147.091, subdivision 1, paragraph (p) (3). The physician has to only acknowledge the fact he or she has direct ownership or control of an asset that is intended to produce a monetary return for them. No further elaboration or description of the asset, ownership or control is required.

The definition also inherently recognizes the Board has jurisdiction over physicians individually and thus can only become involved in cases where the physician is directly involved or has control. This wording also simply recognizes that a monetary return is the basis for the ownership or control.

The second reason for defining "financial interest" in broad terms is to provide a basic general definition for "significant financial interest", (part 5620.0110, subpart 5) thus providing continuity of terminology between the two rules and the statute. Since both definitions are contained with Minnesota Statutes, section 147.091, subdivision 1, paragraph (p) (3) it is necessary the definitions build on each other to avoid confusion.

The wording of "financial interest" is closely modeled after the definition of "financial interest" used by the Minnesota Ethical Practices Board. This wording thus uses a widely recognized definition and one applicable to all public officials. The definition was modified to state that physician ownership or

control of an asset must be direct. This was necessary to because the Board only has jurisdiction over physicians and could not sanction other parties to the transaction such as family members.

The language of the rule containing the exclusion of physician ownership of a building where space is leased to an individual or organization in a straight lease at the prevailing rate and the exclusion of interests held by physicians in a publicly traded stock is modeled after California Statutes, Business and Professions Code, section 654.2, paragraph (d)(3)(e) (1984). This exclusion is reasonable because it recognizes that physicians do not have a "referral relationship" as viewed under the fee splitting regulations. In the first instance, the physician would be a landlord rather than a business partner and have no direct concern in providing business to the lessee. With the ownership or interest in publicly traded stocks, the physician's interest is as a shareholder rather than owner of the business enterprise involved. Thus, his or her interests are managed by others and no direct control exists.

Subpart 5: <u>Profit interest. "Profit interest" means a financial amount received by the physician that exceeds the acquisition cost of a drug or device plus the cost of having the drug or device available.</u>

It is necessary that "profit interest" be defined in order that physicians understand what must be disclosed under Minnesota Statutes, section 147.091, subdivision 1, paragraph (p) (4). In

order to avoid coming under the prohibitions of Minnesota Statute 147.091, Subdivision 1, (p) a physician must disclose his or her profit interest in a drug or device which they dispense for profit.

The definition "profit interest" uses two cost components. They are the cost of acquiring a drug or device and the cost of making it available (overhead). These cost components are easily ascertained and provide a single measure of profit. Anything calculated as profit would then fall into the disclosure provisions.

The previous definitions of drugs and device also help narrow the definition of "profit interest" by indicating what types of drugs and devises are not within the rules and statute.

The language of the definition of "profit interest" is clear, brief and uses terminology understood by the average physician. It also sets a reasonable standard which recognizes that physicians have both item cost and overhead cost to take care of before realizing a profit. This standard can be determined without much difficulty using standard accounting methods.

Subpart 6: Significant financial interest. "Significant financial interest" means any financial interest as defined in subpart 4 that is equal to or greater than five percent of the whole or $5,000, whichever is the lesser amount.

It is reasonable and necessary to define "significant financial interest" in order that physicians know when they must

make disclosure of their financial interest as required under Minnesota Statutes, section 147.091, subdivision 1, paragraph (p) (3).

The term "significant financial interest" is defined using the general "financial interest" definition of subpart 4 and adding a specific percentage of interest (at least 5% of the whole) or financial amount ($5,000 or more) standard that triggers a disclosure under Minnesota Statutes, section 147.091, subdivision 1, paragraph (p) (3). The language of the definition is modeled after California Statutes, Business and Professions Code, section 654.2, paragraph (d)(2)(A)(B) (1984), definition of "significant beneficial interest".

Using the California standards, the definition of "significant financial interest" incorporates standards which have been recognized and used by practicing physicians. The $5,000 or greater interest standard is a recognition that the Board's intervention will not occur over minor financial arrangements but at a financial point which is legally significant. The $5,000 figure while above the conciliation court minimum of $2,000 is still below the $15,000 limit of the higher courts thus representing a reasonable compromise regarding legal significance relative to consumers and physicians.

The five percent of the whole or more standard again represents the Board's interest in not reviewing minor financial situations. Setting the minumum standard of 5% of the whole provides a figure low enough that consumers recognize the physician is looking into an investment or financial relationship

or arrangement upon which to grow rather than just a symbolic or token holding.

5620.0120 INCORPORATION BY REFERENCE OF CRITERIA TO DEFINE DEVICE

The most recent edition of the United States Pharmacopoeia-National Formulary and its supplements are incorporated by reference. The publication is issued by the United States Pharmacopoeial Convention Inc., 12601 Twinbrook Parkway, Rockville, Maryland, 20852. It is available for inspection and copying through the Minitex interlibrary loan system. The publication is subject to change.

The provision is necessary to incorporate by reference the United States Pharmacopoeia-National Formulary into the definition of device. The recognition of the information contained in this publication is essential to the understanding of the criteria for defining device under the proposed fee splitting rules.

5620.0130 DISCLOSURE REQUIREMENTS AND FORMATS

Subpart 1. Written disclosure required.
The disclosure requirements in Minnesota Statutes, section 147.091, subdivision 1, paragraph (p), are met if the written

disclosure is made before a referral. The written disclosure must reasonably apprise the patient or patient's guardian of the physician's financial and profit interest in the individual or entity to which the physician is making the referral, and contain a statement that the patient is free to choose providers other than the one recommended by the physician. The written disclosure must consist of one of the formats in items A to D.

A. The posting of a conspicuous sign in an area that is likely to be seen by the patients and patients' guardians who use the physician's facility.

B. The incorporation of a conspicuous written notice in existing office documents used by the physician. Office documents may include, but are not limited to, prescription sheets, office information or policy booklets, referral forms, and any similar regularly distributed information handout.

C. The use of a written disclosure document that is given to a patient or patient's guardian for review. A copy of the document must be provided to the patient or patient's guardian.

D. A combination of the written disclosure formats described in items A to C.

It is essential to the implementation of Minnesota Statutes, section 147.091, subdivision 1, paragraph (p) that disclosure formats be clearly described to insure physicians have the means to comply with Minnesota Statutes, section 147.091, subdivision 1, paragraph (p) clauses (2), (3), and (4).

The language of this provision sets out the basic content and format requirements for compliance with Minnesota Statutes, section 147.091, subdivision 1, paragraph (p) clauses (2), (3), and (4). The rule, for both clarity and consistency, reemphasizes portions of Minnesota Statute, section 147.091, subdivision 1, paragraph (p), clause (4) regarding disclosure requirements. These points are that disclosures must be made in advance, in writing to the patient, and include a statement that the patient is free to choose a different health care provider. The rule also contains a basic content standard concerning what financial and/or profit interest need to be disclosed. This content standard is information sufficient to reasonably apprise the patient or patient's guardian of the physician's financial and profit interest in the individual or entity to which the physician is making the referral.

The words "reasonably apprise" mean to give enough information to a patient or patient's guardian such that they recognize the physician has a "referral" relationship and that there is a financial and/or profit interest in the relationship. Thus, at the very least, the physician must acknowledge the "referral relationship" in the disclosure, identify the party the referral is being made to, and state they have a financial and/or profit interest involved.

Using this "acknowledgment" approach regarding the content standard for disclosure, the Board has kept the amount of information to be disclosed at a minimum but still sufficiently clear for a consumer to take notice the physician has an economic

interest in the referral.

By combining the "acknowledgment of financial and/or profit interest" approach with the "caveat statement" regarding the option to choose other health care providers, the information in the disclosure is sufficient to identify the parties involved (physician/health care provider), their relationship (referral/dispensing for profit), the physician's interest (financial or profit), and still illuminate the fact that other providers are available. In keeping with concept of simplicity of communication, the disclosure formats themselves were designed to contain only a limited amount of information.

The three different formats for disclosure (conspicuous sign, notice in office documents and written disclosure document) lend themselves to brief, attention-getting wording rather than lengthy narratives. These formats are considered formats currently in existence in most physicians' practices. Thus, disclosure information would be incorporated into existing communication mechanisms rather then requiring development of new systems. By having three different formats and the option to use combinations of formats, physicians have multiple means to evidence compliance with Minnesota Statutes, section 147.091, subdivision 1, paragraph (p) and proposed rule part 5620.0140 EVIDENCE OF DISCLOSURE. Also, multiple formats would facilitate consumer awareness of the required disclosure.

The concept of using signs to make disclosure of physician economic interests has been recognized in California (See California Business and Professions Code section 654.2(D).) The

use of disclosure documents or handouts has been recognized in Arizona and Virginia (See Laws of Arizona, Section 32-1401 (12.) (ff) (1988) and Virginia Code, section 54.1-2964 (1988).

Keeping the disclosure content and formats simple allows physicians and consumers to communicate. With communication between physicians and consumers about physicians' economic interests, consumers can determine for themselves the choice of a health care provider. With greater consumer awareness of health care choices, greater flexibility in structuring of medical-economic relationships can occur because of greater physician accountability to consumers' interests.

The essence of the disclosure provisions of Minnesota Statutes, section 147.091, subdivision 1, paragraph (p) and this rule is to allow physicians to expand their economic interests, so long as they are accountable to their patient-consumers. With disclosure, consumer choice is the economic regulator rather than the fee splitting prohibitions of the Board.

Subpart 2: Unwritten disclosure; when allowed. A nonwritten disclosure format may be used to satisfy the disclosure requirements of Minnesota Statutes, section 147.091, subdivision 1, paragraph (p), when necessary to accommodate the physical condition of a patient or the patient's guardian that makes use of written disclosure alone unworkable.

This provision is necessary to fulfill the intent of

Minnesota Statute, section 147.091, subdivision 1, paragraph (p) insuring disclosure is made to all consumers. Because a written document may not be practical with a patient who is blind or illiterate, a physician is not released from their obligation to provide disclosure to the patient who is unable to read or see. The purpose of this provision is to allow physicians to use nonwritten disclosure formats in addition to written disclosure formats without fear of being penalized for acting outside of the disclosure provision of Minnesota Statutes, section 147.091, subdivision 1, paragraph (p).

Subpart 3: Information must be updated. The disclosure information shall be updated to show any change in the circumstances regarding the physician's financial or profit interest.

This provision is necessary to provide consumers with the most current status regarding their physician's financial and profit interests. By gearing changes in disclosure information to changes in the financial or profit interests of the physician, the physician knows when a change is necessary rather than having to remember timetables where periodic updating would be required.

The rule also recognizes that change must involve the circumstances of the financial or profit interest not just a fluctuation in the amount of interests owned or controlled. Any change represents a significant change in control or ownership

by the physician. By the change being significant it is more readily identifiable to the physician who must determine if updating is required and also more understandable for consumers who would recognize a basic change in control or ownership more easily than just variations in the amount of interest involved when a disclosure is made.

5620.0140 EVIDENCE OF DISCLOSURE

When the board investigates a violation of Minnesota Statutes, section 147.091, subdivision 1, paragraph (p), the burden of proof is on the physician investigated to show evidence the physician complied with disclosure requirements in part 5620.0130.

This provision is reasonable and necessary in order to inform physicians that the Board will look to their compliance with part 5620.0130 as a defense to a complaint submitted to the Board alleging a fee splitting law violation. The provision also serves as a reminder to physicians that using the disclosures provisions contained within Minnesota Statutes, section 147.091, subdivision 1, paragraph (p) will enable them to have certain fee splitting arrangements, practices and relationships without fear of sanction by the Board. The effect of using the disclosure provisions of Minnesota Statutes, section 147.091, subdivision 1, paragraph (p) is to provide physicians

greater flexibility with the structuring of medical-economic arrangements, practices and relationships.

5620.0150 DISCLOSURE OF PROPRIETARY INFORMATION

Specific contract terms or similar proprietary information relating to a physician's financial and profit interest is not required to be part of the information provided in a disclosure under part 5620.0130.

This provision is essential in clarifying for physicians what information is necessary in a disclosure made under Minnesota Statutes, section 147.091, subdivision 1, paragraph (p). By indicating that contract terms or similar proprietary information are not required to be incorporated in a disclosure, the Board is maintaining the idea of a simple disclosure that is easily understood by consumers and easily developed by and implemented by physicians. The rule also preserves the confidentiality of contracts and avoids disclosure of internal business matters.

Under this provision, the physician has the option to use contract or proprietary information in a disclosure but is not mandated to list such information nor is sanctioned for not providing it.

Here again, the Board recognizes consumer understanding is essential and that any disclosure is intended to generate a dialogue between consumers and physicians rather than substitute

for it.

5620.0150 DIVISION OF FEES

In reviewing a division of fees as described in Minnesota Statutes, section 147.091, subdivision 1, paragraph (p), clause (2), the board may consider but is not limited to the following factors regarding the reasonableness of a proportional division of fees:

A. the value of professional services;

B. overhead costs;

C. time and distance traveled; and

D. the availability of the service or product elsewhere in the local trade area.

It is reasonable and necessary that physicians understand what factors the Board will consider when reviewing terms of a division of fees between physicians or a physician and a professional corporation. By providing a list of terms, the Board is also establishing a minimal standard regarding the elements to be contained in a disclosure discussing a proportional division of fees.

The terms used are reflective of recurring comment received by the Board on division of fees. While not the subject of the comment, the terms were illustrative of what commenting individuals viewed division of fee arrangement or contract provisions to contain.

The terms are easily definable using ordinary accounting principles, mathematics, or survey measures and thus do not require further elaboration by the Board.

SUMMATION

Proposed rules part 5620.0100 to 5620.0160 are the Board's effort to make Minnesota Statutes, section 147.091, subdivision 1, paragraph (p) a usable law for both physicians and consumers. They represent the balancing of greater consumer awareness with greater flexibility in the structuring of physician financial arrangements. Disclosure of financial interests and/or profit interests in drug or devices is the key to achieving this balance.

The rules are designed to make disclosure minimal yet effective. Using existing communication formats with the combination of basic identifying information and a consumer choice caveat, provides a detailed yet understandable means of conveying the idea of choice to consumer. The disclosure lets the consumer ask the next question or questions to the physician about what the interest means.

The law and rules allow permissible fee splitting arrangements, practices and relationships. This allows physicians to be more competitive in general and therefore may open new doors for patient access to health care.

The ultimate purpose of these rules and Minnesota Statutes, section 147.091, subdivision 1, paragraph (p) is to let consumers

and physicians determine the course of their financial interaction. By generating the discussion of consumer choice, the exercise of choice by consumers becomes the market regulator and from it new consumer oriented physician financial arrangements and structures will emerge.

4. COMPLIANCE WITH PROCEDURAL RULEMAKING REQUIREMENTS

Minnesota Statutes, section 14.05-14.12 and 14.22-14.28, specify certain procedures which must be followed when an agency adopts or amends rules. Procedures applicable to all rules, Minnesota Statutes, section 14.05-14.12, have been complied with by the Board as noted below. The procedures for adoption of non-controversial rules in sections 14.22 to 14.28 are being used, except that no public hearing is presently planned and need not be held unless 25 or more persons make a timely written request for a public hearing.

The adoption of these rules will not require the expenditure of public money by local public bodies, nor do the rules have any impact on agricultural land. The adoption of these rules could have negligible effect on small businesses as discussed below. See Minnesota Statutes, section 14.115.

Pursuant to Minnesota Statutes, section 14.23, the Board has prepared this Statement of Need and Reasonableness which is available to the public. The Board will publish a notice of Intent To Adopt Rules Without a Public Hearing in the State Register and mail copies of the notice and proposed rules to

persons registered with the Minnesota Board of Medical Examiners pursuant Minnesota Statutes, section 14.14, Subdivision 1a. The notice will include the following information: a) that the public has thirty days in which to submit comments on the proposed rules and giving information pertaining to the manner in which persons may comment; b) that no public hearing will be held pursuant to Minnesota Statutes, section 14.25, unless 25 or more persons request in writing a public hearing on the proposed rule within the 30 day comment period; c) that the rule may be modified if modifications are supported by data and the view submitted; and d) that notice of the date of submission of the proposed rules to the Attorney General for review will be mailed to any persons requesting to receive the notice and giving information on how to request the notice.

5. ADDITIONAL REQUIREMENTS

Small Business Considerations. In preparing these rules, the Board considered the methods for reducing the impact of the rules on small businesses as set forth in Minnesota Statutes, section 14.115, subdivision 2 (1984). The Board noted the suggested methods for reducing the impact of the rules on small businesses concern compliance and reporting requirements and performance standards. There would appear to be no significant impact on small businesses since the fee splitting statute and rule involves only licensed Minnesota physicians and not all small businesses as defined in Minnesota Statute, section 14.115.

However, the Board recognizes physicians may fit within the definition of small businesses as found in Minnesota Statutes, section 14.115 and has attempted to provide opportunities for physicians qualifying under the definition of "small businesses" to participate in the rulemaking process. This was done by the Board conducting a series of Forums on the fee splitting law across Minnesota. All physicians were encouraged to offer their input at the Forum or write to the Board with any comments, criticisms or suggestions on the proposed rules.

147.01 subd 3 The board shall elect ...
The board shall have authority to adopt rules as may be necessary to carry out the purposes of this chapter.

Rules

5620.0130 Disclosure Requirements and Formats
subpart 1 A. B,

A. The requirements are vague. The rule states you must post a conspicuous sign but what should the sign say - how large the printing the sign may be conspicuous but can you read it (A)

good pt but OK but the sentence is enough

B. -no requirement that the notice is given prior to the referral. What good does it do me if the notice is put on my bill after I have already used the referral?

subpt 1 stylistic & clarity Notice

subpt 3. change should be defined as is own 4% of a company and increase it to 4.1% is that a change or it

Say "any change"

Is put $100 more in a company is that a change

Why isn't the physician required to also list other companies or health care provider that could provide the same service as the one he recommends ie if the doctor prescribes a device why isn't he required to give the names of other companies that sell it. It is probably very difficult for patients to locate medical companies that sell medical devices.

5620.0160

to vague - not limited to that could mean everything

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE THE MINNESOTA

BOARD OF MEDICAL EXAMINERS

In the Matter of the
Proposed Adoption of
Rules of the
Board of Medical Examiners
Relating to Fee Splitting

FINDINGS OF FACT,
CONCLUSIONS, AND ORDER
ADOPTING RULES WITHOUT
A PUBLIC HEARING

(1) Notice of the Board of Medical Examiners (hereinafter "Board") intent to adopt the above-entitled rules was published in the State Register on July 10, 1989, and was sent by United States mail to all persons on the list maintained by the Board pursuant to MN Stat. §§ 14.14, subd. 1a and 14.22 on July 10, 1989. (2) The statement of need and reasonableness was prepared before the Notice of Intent to Adopt Rules Without a Public Hearing was mailed to all persons on the rulemaking mailing list and published in the State Register and was available to the public.

(4) All persons were given the opportunity to submit comment on the rules for 30 days after notice of proposed rulemaking. (5) The Board received three requests for a public hearing. Therefore, the Board did not receive requests for a public hearing from 25 or more persons which were not withdrawn.

Eight submissions or comments on the rules were received by the Board. (7) Three requests for notice of submission to the Attorney General were received by the Board.

(8) Based on the comments and evidence in the record before the Board, including the statement of need and reasonableness which is incorporated herein as the Board's findings, the Board concludes that the above-captioned rules are both needed and reasonable.

(9) NOW, THEREFORE, IT IS HEREBY ORDERED that the rules identified as Rules Relating to Fee Splitting are adopted this 16th day of September, 1989, pursuant to authority vested in the Board by MN Stat. §147.01, Subd. 3.

(9) /s/ Leonard Boche
Name

Executive Director
Title

In the Matter of the Proposed Adoption
of the Rule of the MN Board of Medical Examiners
Governing Fee Splitting by Physicians

AFFIDAVIT OF
MAILING THE
NOTICE OF INTENT
TO ADOPT A
RULE WITHOUT
A PUBLIC HEARING
AND
CERTIFICATE OF
MAILING LIST

STATE OF MINNESOTA)
)ss.
COUNTY OF RAMSEY)

H. Leonard Boche, being sworn says:

I hereby certify that the list of persons and associations who have requested, pursuant to Minnesota Statutes, sections 14.14, subdivision 1a and 14.22 or 14.30, that their names be placed on the Board of Medical Examiners rulemaking mailing list is accurate, complete, and current as of this 10th day of July, 1989.

That on the 10th day of July, 1989, at the City of St. Paul, County of Ramsey, State of Minnesota, I mailed the attached Notice of Intent to Adopt A Rule Without a Public Hearing by depositing in the United States mail a copy thereof, with postage prepaid, to all persons and associations on the aforementioned mailing list.

H. Leonard Boche
[Name]

Executive Director
[Title]

Subscribed and sworn to before me
this 31st day of August, 19 89.

Lois Kauppila

LOIS KAUPPILA
NOTARY PUBLIC-MINNESOTA
RAMSEY COUNTY
MY COMMISSION EXPIRES APRIL 28, 1992

STATE OF MINNESOTA
COUNTY OF RAMSEY

BEFORE THE MINNESOTA
BOARD OF MEDICAL EXAMINERS

In the Matter of the
Proposed Adoption of
the Rules of the Board
of Medical Examiners
Relating to Fee-Splitting

AFFIDAVIT OF MAILING OF
PROPOSED FEE-SPLITTING
RULES TO PHYSICIANS LICENSED
BY THE BOARD OF MEDICAL EXAMINERS

STATE OF MINNESOTA
COUNTY OF RAMSEY

H. Leonard Boche, being duly sworn says:

I am Executive Director of the Minnesota Board of Medical Examiners.

That on the 26th day of June, 1989, a purchase order was submitted from the Board of Medical Examiners (herinafter "Board") to the Minnesota Department of Health, 717 Delaware Street SE, Minneapolis, Minnesota, (hereinafter "Department of Health") to release funds necessary for the copying and mailing of a copy of the attached Proposed Rules Relating to Fee-Splitting to all physicians licensed by the Board.

That on the 27th day of June, 1989, the Bureau of Administration, MN Department of Health had 15,544 address labels printed for all physicians currently licensed by the Board as of that date.

That on the 14th day of July, 1989, 15,600 copies of the attached Proposed Rules Relating to Fee-Splitting were sent to the Minnesota Department of Administration, Print Communications Division, Operations Management Bureau, 117 University Avenue, St. Paul, Minnesota (hereinafter "Print Communication Division")by the Bureau of Administration of the Minnesota Department of Health.

That on the 14th day of July, 1989, the Print Communications Division mailed the attached copy of the Proposed Rules Relating to Fee-Splitting to 6,775 physicians licensed by the Board as of June 27, 1989, by depositing in the State of Minnesota Central Mail System for Unites States mailing, a copy thereof, with postage prepaid.

That on the 17th day of July, 1989, the Print Communications Division mailed the attached copy of the Proposed Rules Relating to Fee-Splitting to the 8,769 remaining physicians licensed by the Board as of June 27, 1989, by depositing in the State of Minnesota Central Mail System for United States mailing, a copy thereof, with postage prepaid.

The foregoing is true and accurate upon by own knowledge or upon information and belief and I, therefore, certify that a copy of the Proposed Rules Relating to Fee-Splitting was mailed to all physicians licensed as of June 27, 1989 by the Minnesota Board of Medical Examiners.

H. Leonard Boche
Executive Director

Subscribed and sworn to before me
on this 28th day of November, 1989.



Rules as Proposed (all new material)

5620.0100 PURPOSE.

The purpose of *Minnesota Statutes*, section 147.091, subdivision 1, paragraph (p), and parts 5620.0110 to 5620.0160 is to protect consumers against medical-economic arrangements, practices, and relationships by physicians that unnecessarily increase the cost of health care to consumers, restrict consumer access to goods and services, and otherwise present harm to consumer interests. The board shall comply with *Minnesota Statutes*, section 147.091, subdivision 1, paragraph (p), and parts 5620.0110 to 5620.0160 in evaluating complaints received by the board relating to medical-economic arrangements, practices, or relationships among health care providers.

5620.0110 DEFINITIONS.

Subpart 1. **Scope.** As used in *Minnesota Statutes*, section 147.091, subdivision 1, paragraph (p), the following terms have the meanings given them.

Subp. 2. **Device.** "Device" means an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article including a component, part, or accessory, that as a completely assembled article exceeds $99 in cost and is:

A. recognized in the official United States Pharmacopoeia and National Formulary and its supplements;

B. intended for use in diagnosing disease or other conditions, or in curing, mitigating, treating, or preventing disease in a person;

C. intended to affect the structure or function of the body of a person, and that does not achieve any of its principal intended purposes through chemical action within or on the body of a person and is not dependent upon being metabolized for the achievement of any of its principal intended purposes; or

D. restricted under federal law to sale by or on the order of a licensed practitioner.

Nondurable medical equipment, meaning a supply or piece of equipment that is used to treat a health condition and cannot be reused, is excluded from this definition of device.

Subp. 3. **Drugs.** "Drugs" has the meaning in part 5600.0100, subpart 8.

Subp. 4. **Financial interest.** "Financial interest" means an asset that is directly owned or controlled by an individual or business and that has the potential to produce a monetary return.

Financial interest does not include the ownership of a building by a physician where space is leased to an individual or organization at the prevailing rate in a straight lease agreement or any interest held by a physician in a publicly traded stock.

Subp. 5. **Profit interest.** "Profit interest" means a financial amount received by the physician that exceeds the acquisition cost of a drug or device plus the cost of having the drug or device available.

Subp. 6. **Significant financial interest.** "Significant financial interest" means any financial interest as defined in subpart 4 that is equal to or greater than five percent of the whole or $5,000, whichever is the lesser amount.

5620.0120 INCORPORATION BY REFERENCE OF CRITERIA TO DEFINE DEVICE.

The most recent edition of the United States Pharmacopoeia and National Formulary and its supplements are incorporated by reference. The publication is issued by the United States Pharmacopeial Convention, Inc., 12601 Twinbrook Parkway, Rockville, Maryland, 20852. It is available for inspection and copying through the Minitex interlibrary loan system. The publication is subject to change.

5620.0130 DISCLOSURE REQUIREMENTS AND FORMATS.

Subpart 1. **Written disclosure required.** The disclosure requirements in *Minnesota Statutes*, section 147.091, subdivision 1, paragraph (p), are met if the written disclosure is made before a referral. The written disclosure must reasonably apprise the patient or patient's guardian of the physician's financial and profit interest in the individual or entity to which the physician is making the referral, and contain a statement that the patient is free to choose providers other than the one recommended by the physician. The written disclosure must consist of one of the formats in items A to D.

A. The posting of a conspicuous sign in an area that is likely to be seen by the patients and patients' guardians who use the physician's facility.

B. The incorporation of a conspicuous written notice in existing office documents used by the physician. Office documents may include, but are not limited to, prescription sheets, office information or policy booklets, referral forms, and any similar regularly distributed information handout.

C. The use of a written disclosure document that is given to a patient or patient's guardian for review. A copy of the document must be provided to the patient or patient's guardian.

D. A combination of the written disclosure formats described in items A to C.

Subp. 2. **Unwritten disclosure; when allowed.** A nonwritten disclosure format may be used to satisfy the disclosure requirements of *Minnesota Statutes*, section 147.091, subdivision 1, paragraph (p), when necessary to accommodate the physical condition of a patient or the patient's guardian that makes use of written disclosure alone unworkable.

Subp. 3. **Information must be updated.** The disclosure information shall be updated to show any change in the circumstances regarding the physician's financial or profit interest.

5620.0140 EVIDENCE OF DISCLOSURE.

When the board investigates a violation of *Minnesota Statutes*, section 147.091, subdivision 1, paragraph (p), the burden of proof is on the physician investigated to show evidence the physician complied with disclosure requirements in part 5620.0130.

5620.0150 DISCLOSURE OF PROPRIETARY INFORMATION.

Specific contract terms or similar proprietary information relating to a physician's financial and profit interest is not required to be part of the information provided in a disclosure under part 5620.0130.

5620.0160 DIVISION OF FEES.

In reviewing a division of fees as described in *Minnesota Statutes*, section 147.091, subdivision 1, paragraph (p), clause (2), the board may consider, but is not limited to, the following factors regarding the reasonableness of a proportional division of fees:

A. the value of professional services;

B. overhead costs;

C. time and distance traveled; and

D. the availability of the service or product elsewhere in the local trade area.

Board of Medical Examiners

Proposed Permanent Rules Relating to Physical Therapy

Notice of Intent to Adopt a Rule Without a Public Hearing

NOTICE IS HEREBY GIVEN that the Minnesota Board of Medical Examiners intends to adopt the above-entitled rule without a public hearing following the procedures set forth in the Administrative Procedure Act for adopting rules without a public hearing in *Minnesota Statutes*, sections 14.22 to 14.28. The statutory authority to adopt the rule is *Minnesota Statutes*, section 148.74.

All persons have 30 days in which to submit comment in support of or in opposition to the proposed rule or any part or subpart of the rule. Comment is encouraged. Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rule within the 30-day comment period. If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. If a public hearing is required, the agency will proceed pursuant to *Minnesota Statutes*, sections 14.131 to 14.20.

Comments or written requests for a public hearing must be submitted to:

H. Leonard Boche, Executive Director
Minnesota Board of Medical Examiners
2700 University Avenue West, #106
St. Paul, Minnesota 55114-1080
612-642-0538.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

Minnesota Board of Medical Examiners

EXECUTIVE OFFICE
Suite 106
2700 University Avenue West
St. Paul, Minnesota 55114-1080
(612) 642-0538

July 10, 1989

To: INTERESTED PARTIES

Re: FEE SPLITTING RULES

On July 10, 1989, the Board of Medical Examiners published in the State Register a copy of the proposed rule relating to Fee Splitting and Notice of Intent to Adopt a Rule Without a Public Hearing.

Information regarding submission of comments on the proposed rule; requests for a public hearing on the rule; and requests for copies of the proposed rule and/or Statement of Need and Reasonableness is addressed in the attached Notice of Intent to Adopt a Rule Without a Public Hearing.

If there are any additional questions regarding the proposed rule or the rulemaking process, please call 612-642-0538 or 612-642-0585.

Thank you for your interest and concern.

Sincerely,

H. Leonard Boche

H. Leonard Boche
Executive Director

HLB:blm
Attachment

AN EQUAL OPPORTUNITY EMPLOYER

Subp. 4. **Hearing.** If a hearing on a disciplinary matter is requested by the affected roster member, the commissioner or the commissioner's representative shall convene and conduct a hearing pursuant to part 5510.1910, subparts 6, 8, 9, 10, 12, 13, and 14. Advisory committee members may attend the hearing or review the audio-magnetic recording from the proceedings.

Subp. 5. **Determination.** The commissioner shall determine the action to be taken with respect to the member's status on the roster, based on the record of the hearing, the recommendations of the advisory committee, and this chapter. The determination is a final decision.

Board of Medical Examiners

Proposed Permanent Rules Relating to Fee Splitting

Notice of Intent to Adopt a Rule Without a Public Hearing

NOTICE IS HEREBY GIVEN that the Minnesota Board of Medical Examiners intends to adopt the above-entitled rule without a public hearing following the procedures set forth in the Administrative Procedure Act for adopting rules without a public hearing in *Minnesota Statutes*, sections 14.22 to 14.28. The statutory authority to adopt the rule is *Minnesota Statutes*, section 147.01, subdivision 3.

All persons have 30 days in which to submit comment in support of or in opposition to the proposed rule or any part or subpart of the rule. Comment is encouraged. Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rule within the 30-day comment period. If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. If a public hearing is required, the agency will proceed pursuant to *Minnesota Statutes*, sections 14.131 to 14.20.

Comments or written requests for a public hearing must be submitted to:

H. Leonard Boche, Executive Director
Minnesota Board of Medical Examiners
2700 University Avenue West, #106
St. Paul, MN 55114-1080
612-642-0538

The proposed rule may be modified if the modifications are supported by data and views submitted to the agency and do not result in a substantial change in the proposed rule as noticed.

A copy of the proposed rule is attached to this notice. A free copy of the rule is available upon request from H. Leonard Boche.

A Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relied upon to support the proposed rule has been prepared and is available from H. Leonard Boche upon request.

If no hearing is required, upon adoption of the rule, the rule and the required supporting documents will be submitted to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to H. Leonard Boche.

Dated: 24 April 1989

H. Leonard Boche
Executive Director

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

Rules as Proposed (all new material)

5620.0100 PURPOSE.

The purpose of *Minnesota Statutes*, section 147.091, subdivision 1, paragraph (p), and parts 5620.0110 to 5620.0160 is to protect consumers against medical-economic arrangements, practices, and relationships by physicians that unnecessarily increase the cost of health care to consumers, restrict consumer access to goods and services, and otherwise present harm to consumer interests. The board shall comply with *Minnesota Statutes*, section 147.091, subdivision 1, paragraph (p), and parts 5620.0110 to 5620.0160 in evaluating complaints received by the board relating to medical-economic arrangements, practices, or relationships among health care providers.

5620.0110 DEFINITIONS.

Subpart 1. **Scope.** As used in *Minnesota Statutes*, section 147.091, subdivision 1, paragraph (p), the following terms have the meanings given them.

Subp. 2. **Device.** "Device" means an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article including a component, part, or accessory, that as a completely assembled article exceeds $99 in cost and is:

A. recognized in the official United States Pharmacopoeia and National Formulary and its supplements;

B. intended for use in diagnosing disease or other conditions, or in curing, mitigating, treating, or preventing disease in a person;

C. intended to affect the structure or function of the body of a person, and that does not achieve any of its principal intended purposes through chemical action within or on the body of a person and is not dependent upon being metabolized for the achievement of any of its principal intended purposes; or

D. restricted under federal law to sale by or on the order of a licensed practitioner.

Nondurable medical equipment, meaning a supply or piece of equipment that is used to treat a health condition and cannot be reused, is excluded from this definition of device.

Subp. 3. **Drugs.** "Drugs" has the meaning in part 5600.0100, subpart 8.

Subp. 4. **Financial interest.** "Financial interest" means an asset that is directly owned or controlled by an individual or business and that has the potential to produce a monetary return.

Financial interest does not include the ownership of a building by a physician where space is leased to an individual or organization at the prevailing rate in a straight lease agreement or any interest held by a physician in a publicly traded stock.

Subp. 5. **Profit interest.** "Profit interest" means a financial amount received by the physician that exceeds the acquisition cost of a drug or device plus the cost of having the drug or device available.

Subp. 6. **Significant financial interest.** "Significant financial interest" means any financial interest as defined in subpart 4 that is equal to or greater than five percent of the whole or $5,000, whichever is the lesser amount.

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5620.0130 DISCLOSURE REQUIREMENTS AND FORMATS.

Subpart 1. **Written disclosure required.** The disclosure requirements in *Minnesota Statutes*, section 147.091, subdivision 1, paragraph (p), are met if the written disclosure is made before a referral. The written disclosure must reasonably apprise the patient or patient's guardian of the physician's financial and profit interest in the individual or entity to which the physician is making the referral, and contain a statement that the patient is free to choose providers other than the one recommended by the physician. The written disclosure must consist of one of the formats in items A to D.

A. The posting of a conspicuous sign in an area that is likely to be seen by the patients and patients' guardians who use the physician's facility.

B. The incorporation of a conspicuous written notice in existing office documents used by the physician. Office documents may include, but are not limited to, prescription sheets, office information or policy booklets, referral forms, and any similar regularly distributed information handout.

C. The use of a written disclosure document that is given to a patient or patient's guardian for review. A copy of the document must be provided to the patient or patient's guardian.

D. A combination of the written disclosure formats described in items A to C.

Subp. 2. **Unwritten disclosure; when allowed.** A nonwritten disclosure format may be used to satisfy the disclosure requirements of *Minnesota Statutes*, section 147.091, subdivision 1, paragraph (p), when necessary to accommodate the physical condition of a patient or the patient's guardian that makes use of written disclosure alone unworkable.

Subp. 3. **Information must be updated.** The disclosure information shall be updated to show any change in the circumstances regarding the physician's financial or profit interest.

5620.0140 EVIDENCE OF DISCLOSURE.

When the board investigates a violation of *Minnesota Statutes*, section 147.091, subdivision 1, paragraph (p), the burden of proof is on the physician investigated to show evidence the physician complied with disclosure requirements in part 5620.0130.

5620.0150 DISCLOSURE OF PROPRIETARY INFORMATION.

Specific contract terms or similar proprietary information relating to a physician's financial and profit interest is not required to be part of the information provided in a disclosure under part 5620.0130.

5620.0160 DIVISION OF FEES.

In reviewing a division of fees as described in *Minnesota Statutes*, section 147.091, subdivision 1, paragraph (p), clause (2), the board may consider, but is not limited to, the following factors regarding the reasonableness of a proportional division of fees:

A. the value of professional services;

B. overhead costs;

C. time and distance traveled; and

D. the availability of the service or product elsewhere in the local trade area.

Board of Medical Examiners

Proposed Permanent Rules Relating to Physical Therapy

Notice of Intent to Adopt a Rule Without a Public Hearing

NOTICE IS HEREBY GIVEN that the Minnesota Board of Medical Examiners intends to adopt the above-entitled rule without a public hearing following the procedures set forth in the Administrative Procedure Act for adopting rules without a public hearing in *Minnesota Statutes*, sections 14.22 to 14.28. The statutory authority to adopt the rule is *Minnesota Statutes*, section 148.74.

All persons have 30 days in which to submit comment in support of or in opposition to the proposed rule or any part or subpart of the rule. Comment is encouraged. Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rule within the 30-day comment period. If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. If a public hearing is required, the agency will proceed pursuant to *Minnesota Statutes*, sections 14.131 to 14.20.

Comments or written requests for a public hearing must be submitted to:

H. Leonard Boche, Executive Director
Minnesota Board of Medical Examiners
2700 University Avenue West, #106
St. Paul, Minnesota 55114-1080
612-642-0538.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

CERTIFICATE OF THE
BOARD OF MEDICAL EXAMINERS
RESOLUTION ADOPTING RULES

I, Stephen Kelley, do hereby certify that I am a member and the President of the Minnesota Board of Medical Examiners (hereinafter "Board"), a board duly authorized under the laws of the State of Minnesota, and that the following is a true, complete, and correct copy of a resolution adopted at a meeting of the Board, duly and properly called and held on the 16th day of September, 1989, that a quorum was present, and that a majority of those present voted for the resolution which has not been rescinded or modified:

> RESOLVED, that the rules relating to Fee Splitting are approved and adopted pursuant to authority vested in the Board by Mn Statute §147.01 Subd. 3. H. Leonard Boche, Executive Director of the Board is authorized to sign the findings of fact, conclusions and order adopting the rules and further is authorized to modify the rules if necessary to obtain the approval of the rules by the Attorney General (or other stated circumstances) and to perform the necessary acts to provide that the rules shall have the force and effect of law.

IN WITNESS WHEREOF, I have hereunto subscribed my name this 16th day of September, 1989.

Stephen P. Kelley
President

Attest by one other Board member

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE THE MINNESOTA

BOARD OF MEDICAL EXAMINERS

In the Matter of the
Proposed Adoption of
Rules of the Board of
Medical Examiners
Governing Fee-Splitting

DECLARATION OF COUNSEL

I, John A. Breviu, Assistant Attorney General, do hereby declare that I have examined the above-captioned rules and the supporting rulemaking record and that, based on my examination, the Administrative Procedure Act and Minn. Rules ch. 2010 have been followed. Any exceptions are listed below. For Attorney General billing purposes, the four-digit docket client code is 0480.

Dated: November 28, 1989

JOHN A. BREVIU
Assistant Attorney General

Exception:

The Statement of Need and Reasonableness does not specifically address all five considerations listed in Minn. Stat. § 14.115, subd. 2 (1988). The Statement concludes that there is no significant compliance or reporting requirement for small businesses under the proposed rule. It is, in fact, arguable whether Minn. Stat. § 14.115 (1988) even applies to these rules since physicians are medical care providers and are regulated by the state both as to standards and costs. Accordingly, the exemption in Minn. Stat. § 14.115, subd. 7(c) (1988) may apply.

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE THE MINNESOTA

BOARD OF MEDICAL EXAMINERS

In the Matter of the Proposed Adoption of Rules of the Board of Medical Examiners Governing Fee-Splitting

NOTICE OF SUBMISSION OF RULES ADOPTED WITHOUT A PUBLIC HEARING TO THE ATTORNEY GENERAL

Pursuant to your request and in accordance with Minn. Stat. § 14.26:

PLEASE TAKE NOTICE that the above-captioned rules as adopted have been submitted to the Attorney General on November 28, 1989, for review as to legality and form to the extent form relates to legality. The proposed rules, the rules as adopted, all the notices, the statement of need and reasonableness, all written comments and requests for a hearing received, and other required documents also have been submitted to the Attorney General.

The rules must be approved or disapproved by the Attorney General within 14 calendar days of the date of submission. You may submit written comments to the Attorney General on the legality of the rules. Any written comments must be submitted within eight calendar days of the date of submission. Your comments must address only the issue of legality of the rules or the legality of the specific parts or subparts of the rules. Attorney General standards for review are set forth in Minn. Rules pt. 2010.1000. You may receive a

copy of the Attorney General's decision upon written request to the Attorney General. Your comments or requests for the decision must be directed to:

Attorney General's Office
Government Services Section
404 Capitol Office Building
525 Park Street
St. Paul, Minnesota 55103
Telephone: (612) 297-2040

Any written comments submitted to the Attorney General must be submitted simultaneously to:

H. Leonard Boche
Executive Director
Minnesota Board of Medical Examiners
2700 University Avenue West, Suite 106
St. Paul, Minnesota 55114
Telephone: (612) 642-0538

Dated: November 28th, 1989

/s/ Leonard Boche
H. LEONARD BOCHE
Executive Director

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE THE MINNESOTA

BOARD OF MEDICAL EXAMINERS

In the Matter of the Proposed Adoption of Rules of the Board of Medical Examiners Governing Fee-Splitting

AFFIDAVIT OF MAILING THE NOTICE OF SUBMISSION OF RULES ADOPTED WITHOUT A PUBLIC HEARING TO THE ATTORNEY GENERAL

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

William R. Marczewski, being duly sworn says:

That on the 28 day of November, 1989, in the City of St. Paul, County of Ramsey, State of Minnesota, I mailed the attached Notice of Submission of Rules Adopted Without a Public Hearing to the Attorney General by depositing in the United States mail, a copy thereof, with postage prepaid, to all persons and associations who request notice that the rules in the above-entitled matter have been submitted to the Attorney General.

William R. Marczewski

Subscribed and sworn to before me
this 28th day of November, 1989.

Betty L. Misservey

NOTARY PUBLIC

BETTY L. MISSERVEY
NOTARY PUBLIC MINNESOTA
DAKOTA COUNTY
MY COMMISSION EXPIRES AUGUST 23, 1995

NOTICE OF SOLICITATION OF OUTSIDE INFORMATION OR OPINIONS

Minnesota Board of Medical Examiners

Notice of Solicitation of Outside Information or Opinions Regarding Proposed Rule Governing Fee-Splitting by Physicians.

Notice is hereby given that the Minnesota Board of Medical Examiners is seeking information or opinions from sources outside the agency in preparing to propose the adoption of the rule governing fee-splitting by physicians. The adoption of the rule is authorized by Minnesota Statutes, section 147.01 Subdivision 3, which permits the agency to adopt rules as may be found necessary to carry out the purposes of Chapter 147.

The Minnesota Board of Medical Examiners requests information and opinions concerning the subject matter of the rule. Interested persons or groups may submit data or views on the subject matter of concern in writing or orally.

Written statements should be addressed to:

Minnesota Board of Medical Examiners
2700 University Avenue W. #106
St. Paul, MN 55114-1080

Oral statements will be received during regular business hours over the telephone at 612-642-0538 and in person at the above address.

Any written material received by the Minnesota Board of Medical Examiners shall become part of the rulemaking record to be submitted to the attorney general or administrative law judge in the event that the rule is adopted.

June 23, 1988
DATE

/s/ Gonard Eschle
NAME

Executive Director
TITLE

CERTIFICATE OF THE

MINNESOTA BOARD OF

MEDICAL EXAMINERS

AUTHORIZING RESOLUTION

I, Melvin E. Sigel, MD, do hereby certify that I am a member and the president of the Minnesota Board of Medical Examiners (hereinafter "Board"), a board duly authorized under the laws of the State of Minnesota, and that the following is a true, complete, and correct copy of a resolution adopted at a meeting of the Board duly and properly called and held on the 9th day of July, 1988, that a quorum was present, and that a majority of those present voted for the resolution which has not been rescinded or modified:

> RESOLVED, that H. Leonard Boche, Executive Director of the Board, is hereby granted the authority and directed to sign and to give the Notice of the Board's Intent to Adopt a Rule Amendment Without a Public Hearing governing fee splitting to all persons who have registered their names with the Board for that purpose, to publish the notice and rule amendment in the State Register, and to perform any and all acts incidental thereto.

IN WITNESS WHEREOF, I have hereunto subscribed my name this 27 day of July, 1988.

Melvin Sigel MD

MELVIN E. SIGEL, MD
President

Stephen P. Kelley

Attest by one other Board Member

Board of Medical Examiners

Proposed Permanent Rules Relating to Fee Splitting

Rules as Proposed (all new material)

5620.0100 PURPOSE.

The purpose of Minnesota Statutes, section 147.091, subdivision 1, paragraph (p), and parts 5620.0110 to 5620.0160 is to protect consumers against medical-economic arrangements, practices, and relationships by physicians that unnecessarily increase the cost of health care to consumers, restrict consumer access to goods and services, and otherwise present harm to consumer interests. The board shall comply with Minnesota Statutes, section 147.091, subdivision 1, paragraph (p), and parts 5620.0110 to 5620.0160 in evaluating complaints received by the board relating to medical-economic arrangements, practices, or relationships among health care providers.

5620.0110 DEFINITIONS.

Subpart 1. **Scope.** As used in Minnesota Statutes, section 147.091, subdivision 1, paragraph (p), the following terms have the meanings given them.

Subp. 2. **Device.** "Device" means an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article including a component, part, or accessory, that as a completely assembled article exceeds $99 in cost and is:

A. recognized in the official United States Pharmacopoeia and National Formulary and its supplements;

B. intended for use in diagnosing disease or other conditions, or in curing, mitigating, treating, or preventing disease in a person;

C. intended to affect the structure or function of the body of a person, and that does not achieve any of its principal intended purposes through chemical action within or on the body of a person and is not dependent upon being metabolized

Approved by Revisor

for the achievement of any of its principal intended purposes; or

D. restricted under federal law to sale by or on the order of a licensed practitioner.

Nondurable medical equipment, meaning a supply or piece of equipment that is used to treat a health condition and cannot be reused, is excluded from this definition of device.

Subp. 3. **Drugs.** "Drugs" has the meaning in part 5600.0100, subpart 8.

Subp. 4. **Financial interest.** "Financial interest" means an asset that is directly owned or controlled by an individual or business and that has the potential to produce a monetary return.

Financial interest does not include the ownership of a building by a physician where space is leased to an individual or organization at the prevailing rate in a straight lease agreement or any interest held by a physician in a publicly traded stock.

Subp. 5. **Profit interest.** "Profit interest" means a financial amount received by the physician that exceeds the acquisition cost of a drug or device plus the cost of having the drug or device available.

Subp. 6. **Significant financial interest.** "Significant financial interest" means any financial interest as defined in subpart 4 that is equal to or greater than five percent of the whole or $5,000, whichever is the lesser amount.

5620.0120 INCORPORATION BY REFERENCE OF CRITERIA TO DEFINE DEVICE.

The most recent edition of the United States Pharmacopoeia and National Formulary and its supplements are incorporated by reference. The publication is issued by the United States Pharmacopeial Convention, Inc., 12601 Twinbrook Parkway, Rockville, Maryland, 20852. It is available for inspection and copying through the Minitex interlibrary loan system. The publication is subject to change.

Approved
by Revisor _____

5620.0130 DISCLOSURE REQUIREMENTS AND FORMATS.

Subpart 1. **Written disclosure required.** The disclosure requirements in Minnesota Statutes, section 147.091, subdivision 1, paragraph (p), are met if the written disclosure is made before a referral. The written disclosure must reasonably apprise the patient or patient's guardian of the physician's financial and profit interest in the individual or entity to which the physician is making the referral, and contain a statement that the patient is free to choose providers other than the one recommended by the physician. The written disclosure must consist of one of the formats in items A to D.

A. The posting of a conspicuous sign in an area that is likely to be seen by the patients and patients' guardians who use the physician's facility.

B. The incorporation of a conspicuous written notice in existing office documents used by the physician. Office documents may include, but are not limited to, prescription sheets, office information or policy booklets, referral forms, and any similar regularly distributed information handout.

C. The use of a written disclosure document that is given to a patient or patient's guardian for review. A copy of the document must be provided to the patient or patient's guardian.

D. A combination of the written disclosure formats described in items A to C.

Subp. 2. **Unwritten disclosure; when allowed.** A nonwritten disclosure format may be used to satisfy the disclosure requirements of Minnesota Statutes, section 147.091, subdivision 1, paragraph (p), when necessary to accommodate the physical condition of a patient or the patient's guardian that makes use of written disclosure alone unworkable.

Subp. 3. **Information must be updated.** The disclosure information shall be updated to show any change in the circumstances regarding the physician's financial or profit interest.

Approved
by Revisor _____

5620.0140 EVIDENCE OF DISCLOSURE.

When the board investigates a violation of Minnesota Statutes, section 147.091, subdivision 1, paragraph (p), the burden of proof is on the physician investigated to show evidence the physician complied with disclosure requirements in part 5620.0130.

5620.0150 DISCLOSURE OF PROPRIETARY INFORMATION.

Specific contract terms or similar proprietary information relating to a physician's financial and profit interest is not required to be part of the information provided in a disclosure under part 5620.0130.

5620.0160 DIVISION OF FEES.

In reviewing a division of fees as described in Minnesota Statutes, section 147.091, subdivision 1, paragraph (p), clause (2), the board may consider, but is not limited to, the following factors regarding the reasonableness of a proportional division of fees:

A. the value of professional services;

B. overhead costs;

C. time and distance traveled; and

D. the availability of the service or product elsewhere in the local trade area.

Approved
by Revisor _____

Office of the Revisor of Statutes

Administrative Rules

TITLE: Proposed Permanent Rules Relating to Fee Splitting

AGENCY: Board of Medical Examiners

MINNESOTA RULES: Chapter 5620

INCORPORATION BY REFERENCE:
5620.0120 United States Pharmacopoeia and National Formulary and its supplements

The attached rules are approved for publication in the State Register

Kathleen M. Traxler
Assistant Revisor

Minnesota Board of Medical Examiners

In the Matter of the Proposed
Adoption of the Rule of
the Minnesota Board of Medical Examiners
Governing Fee Splitting by Physicians

NOTICE OF
INTENT TO
ADOPT A RULE
WITHOUT A
PUBLIC HEARING

(1) Notice is hereby given that the Minnesota Board of Medical Examiners intends to adopt the above-entitled rule without a public hearing following the procedures set forth in the Administrative Procedure Act for adopting rules without a public hearing in Minnesota Statutes, sections 14.22 to 14.28. The statutory authority to adopt the rule is Minnesota Statutes, section 147.01, subdivision 3.

(2) All persons have 30 days in which to submit comment in support of or in opposition to the proposed rule or any part or subpart of the rule. Comment is encouraged. (3) Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

(4) Any person may make a written request for a public hearing on the rule within the 30-day comment period. (4) If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. (6) Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. (7) If a public hearing is required, the agency will proceed pursuant to Minnesota Statutes, sections 14.131 to 14.20.

(5) Comments or written requests for a public hearing must be submitted to:

H. Leonard Boche, Executive Director, Minnesota Board of Medical Examiners,
2700 University Avenue West, #106, St. Paul, Minnesota 55114-1080, 612-642-0538

(8) The proposed rule may be modified if the modifications are supported by data and views submitted to the agency and do not result in a substantial change in the proposed rule as noticed.

(11) A copy of the proposed rule is attached to this notice. A free copy of the rule is available upon request from H. Leonard Boche.

(12) A Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relies upon to support the proposed rule has been prepared and is available from H. Leonard Boche upon request.

(9) If no hearing is required, upon adoption of the rule, the rule and the required supporting documents will be submitted to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to H. Leonard Boche.

4/24/89
Date

/s/ H. Leonard Boche
[Name]

Executive Director
[Title]

RECEIVED
JAN 16 1986
MN. MEDICAL ASSN.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

Report: A
(I-86)

Subject: Conflicts of Interest

Presented by: Nancy W. Dickey, M.D., Chairman

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(David B. Horner, M.D., Chairman)

At its 1985 Interim Meeting, the House of Delegates adopted Substitute Resolution 18 which requested the Council on Ethical and Judicial Affairs "to continue to review its 1984 Conflict of Interest Guidelines and to amplify them as needed to address current and emerging situations relating to financial interests of physicians in organizations involved in the provision of medical services." In addition, Board of Trustees Report GG (I-85) on "Integration of the Health Care Sector: Definitions, Trends and Implications" informed the House that the Council on Ethical and Judicial Affairs would "continue to study and suggest means by which physicians may distinguish conflict of interest situations...and further refine its guidelines for their resolution." The House of Delegates adopted the Council's Conflict of Interest Guidelines at its 1984 Interim Meeting (Judicial Council Report C, I-84). The Council's position is:

> Physician ownership interest in a commercial venture with the potential for abuse is not in itself unethical. Physicians are free to enter lawful contractual relationships, including the acquisition of ownership interests in health facilities or equipment or pharmaceuticals. However, the potential conflict of interest must be addressed by the following:
>
> 1. the physician has an affirmative ethical obligation to disclose to the patient or referring colleagues his or her ownership interest in the facility or therapy prior to utilization;
>
> 2. the physician may not exploit the patient in any way, as by inappropriate or unnecessary utilization;

Past House Action: A-86:246;I-85:100-109,231;I-84:175

3. the physician's activities must be in strict conformance with the law;

4. the patient should have free choice either to use the physician's proprietary facility or therapy or to seek the needed medical services elsewhere; and

5. when a physician's commercial interest conflicts so greatly with the patient's interest as to be incompatible, the physician should make alternative arrangements for the care of the patient.

The Council promulgated these guidelines to supplement its opinion on "Health Facility Ownership by Physician" which provides:

> A physician may own or have a financial interest in a for-profit hospital, nursing home or other health facility, such as a free-standing surgical center or emergency clinic. However, the physician has an affirmative ethical obligation to disclose his ownership of a health facility to his patient, prior to admission or utilization.
>
> Under no circumstance may the physician place his own financial interest above the welfare of his patients. The prime objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. For a physician to unnecessarily hospitalize a patient or prolong a patient's stay in the health facility for the physician's financial benefit would be unethical.
>
> If a conflict develops between the physician's financial interest and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit. (Section 4.05, CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, 1986)

The principle of resolving conflicts to the patient's benefit is derived from the physician's role as a fiduciary, i.e., a person who, by his undertaking, has a duty to act primarily for another's benefit in matters connected with that undertaking. The ethical issue for the physician is <u>how</u> to resolve conflicts of interest to the patient's benefit. Suggestions for resolving conflicts of interest are predicated on the fact that, at a minimum, they must be resolved in compliance with the law and public policy. Individual physicians may, of course, choose the strictest personal moral course, e.g., totally avoiding potential conflicts by avoiding financial interests in the health care facilities or products or devices used in the provision of medical and health care services. Nevertheless, a middle ground is ethically permissible as long as the patient's welfare remains the priority. As professionals, physicians are committed to something more than personal gain. It has been well stated that:

> Historically, there are three ideas involved in a profession: organization, learning, i.e., pursuit of a learned art, and a spirit of public service. These are essential. A further idea, that of gaining a livelihood is involved in all callings. It is the main if not the only purpose in the...money-making callings. In a profession it is incidental. (R. Pound, THE LAWYER FROM ANTIQUITY TO MODERN TIMES, 1953, p.6).

In medicine, the tenet that financial interest should not interfere with the physician's medical judgments on behalf of the patient is ancient and is exemplified in Maimonides' Prayer (ca. 1190): "Do not allow thirst for profit, ambition for renown and admiration, to interfere with my profession for these are the enemies of truth and can lead me astray in the great task of attending to the welfare of Your creatures."

The public policy of entrepreneurialism has been suggested as a compelling impetus for each physician to examine any financial arrangement that may interfere or appear to interfere with the exercise of his best medical judgment on behalf of the patient. The Institute of Medicine has noted:

> All compensation systems - from fee-for-service to capitation or salary - present some undesirable incentives for providing too many services, or too few. No system will work without some degree of integrity, decency, and ethical commitment on the part of professionals. Inevitably, we must presume some underlying professionalism that will constrain the operation of unadulterated self-interest. The question is not to find a set of incentives that is beyond criticism, but to seek arrangements that encourage the physician to function as a professional, in the highest sense of that term. Certain changes that are occurring in our increasingly entrepreneurial health care system could undermine patients' trust in their physicians and society's trust in the medical profession. For those who believe that the professionalism of the physician is an essential element in ensuring the quality of health care and the responsiveness of institutions to the best interests of patients, an important question is whether that professionalism will be undermined by the increasingly entrepreneurial health care market in which physicians play a major part. (B.H. Gray, ed. FOR-PROFIT ENTERPRISE IN HEALTH CARE, 1986, p.153).

This report will identify situations that may give rise to conflicts of interest and provide suggestions for resolving them to the patient's benefit in conformity with the Council's guidelines, and in conformity with relevant public policies. Examples of conflicts of interest between the physician and the patient are provided (a) in the absence of third parties; and (b) in the presence of third parties.

SITUATIONS WITH THE POTENTIAL FOR CONFLICT OF INTEREST

Example 1: Physician dispenses drug or device to patient for profit.

Discussion: Unlike the situation where a physician prescribes a drug or device produced by a company in which he holds publicly traded stock whose profits and losses are determined by market forces, physician dispensing of drugs or devices and profiting directly thereby creates a conflict of interest if these are available through normal channels.

Public policies of several states prohibit physicians' dispensing where there is exploitation of the patient but permit it where there is disclosure and patient choice.[1]

Relevant opinions of the Council on Ethical and Judicial Affairs are:

> Drugs and Devices: Prescribing. A physician should not be influenced in the prescribing of drugs, devices or appliances by a direct or indirect financial interest in a pharmaceutical firm or other supplier. Whether the firm is a manufacturer, distributor, wholesaler or repackager of the products involved is immaterial. Reputable firms rely on quality and efficacy to sell their products under competitive circumstances and do not appeal to physicians to have financial involvements with the firm in order to influence their prescribing.
>
> Patients have an ethically and legally recognized right to prompt access to the information contained in their individual medical records. The prescription is an essential part of the patient's medical record. Physicians should not discourage patients from requesting a written prescription or urge them to fill prescriptions at an establishment which has a direct telephone line or which has entered into a business or other preferential arrangement with the physician with respect to the filling of the physician's prescription. (Section 8.06, CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, 1986)
>
> Fee Splitting: Drug Prescription Rebates. A physician may not accept any kind of payment or compensation from a drug company for prescribing its products. The physician should keep the following considerations in mind: (1) A physician should only prescribe a drug based on his reasonable expectations of the effectiveness of the drug for the particular patient. (2) The quantity of the drug prescribed should be no greater than that which is reasonably required for the patient's condition. (Section 6.06, CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, 1986)

RECOMMENDATION I:

ALTHOUGH THERE ARE CIRCUMSTANCES IN WHICH PHYSICIANS MAY ETHICALLY ENGAGE IN THE DISPENSING OF DRUGS, DEVICES OR OTHER PRODUCTS, PHYSICIANS ARE URGED TO AVOID REGULAR DISPENSING AND RETAIL SALE OF DRUGS, DEVICES OR OTHER PRODUCTS WHEN THE NEEDS OF PATIENTS CAN BE MET ADEQUATELY BY LOCAL ETHICAL PHARMACIES OR SUPPLIERS.

Example 2: Physician refers patient to a facility or service owned by the physician in whole or in part.

Discussion: The Council's opinion on "Health Facility Ownership by Physician" (supra) applies. For example, the Council has stated that "A physician may own or operate a pharmacy if there is no resulting exploitation of patients." Under the Council's Conflict of Interest Guidelines, the physician-pharmacy owner would have to (1) disclose his ownership interest in the pharmacy; (2) prescribe only that quantity of a drug which is reasonably required for the patient's condition; (3) comply with all applicable laws, including those that restrict referrals to the physician's facility; (4) provide the patient with a written prescription so that the patient can have it filled wherever he wishes; and (5) make alternative arrangements for the care of the patient if the physician's commercial interest conflicts so greatly with the patient's interest as to be incompatible.

Public policies, as reflected in various statutes, range from the extremes of prohibiting referral to the physician's entity to no restrictions through the middle course of requiring disclosure of the ownership interest and patient choice.[2]

The ethical analysis requires an initial determination of what degree of financial interest creates a potential conflict with the patient's best interests. Where the physician's income is directly related to his ownership interest, there is a potential conflict. This conflict is most apparent where the physician is the sole owner of the entity to which he refers his patients. Failure to disclose an ownership interest which directly yields a financial benefit to the referring physician would be deceitful. Yet, it is in this situation that disclosure to the patient should be the easiest. A potential conflict of interest may also exist where the physician is a partial owner of the entity to which he refers his patients. In a situation where the physician is a partner or shareholder in the facility to which he refers his patient, the financial benefit to the referring physician may be so indirect and/or negligible as to create no conflict with his medical judgment. However, the appearance of impropriety for failing to disclose even a negligible financial benefit should be avoided by adherence to the Council's Conflict of Interest Guidelines. (See also Example 4 where physician's income is related to referrals to or from a third party.) The method of disclosing a physician's financial interest is that which makes it

known to the particular patient. As a practical matter, a written roster of physician owners can be made available to the patient.

RECOMMENDATION: II

IN ACCORDANCE WITH THE COUNCIL'S CONFLICT OF INTEREST GUIDELINES, PHYSICIANS MAY REFER PATIENTS TO FACILITIES IN WHICH THEY HAVE AN OWNERSHIP INTEREST. HOWEVER, PHYSICIANS SHOULD SEEK TO AVOID EVEN THE APPEARANCE OF IMPROPRIETY IN MEDICAL DECISIONS THAT ARE EVEN REMOTELY RELATED TO THEIR FINANCIAL INTERESTS.

Example 3: Physician pays or is paid by third party for referral of patients.

Discussion: The classic example would be an instance where a physician refers a patient to another physician who remits a portion of the fee to the referring physician. Fee splitting has long been abhored by the medical profession. Referral on the basis of the physician's financial interest rather than confidence in the competence and ability to perform the services needed by the patient violates the physician's duty to deal honestly with patients and may result in the provision of unnecessary services.

It appears that most states have statutes making fee splitting or referral fees crimes or grounds for disciplinary action.[3] State statutes vary and their application to newly emerging business arrangements is problematical. For example, acceptance by a physician of an inducement to admit all of one's patients to the health facility of one offering the inducement might be construed as fee splitting.

The relevant opinions of the Council on Ethical and Judicial Affairs are:

> Fee Splitting. Payment by one physician to another solely for the referral of a patient is fee splitting and is improper both for the physician making the payment and the physician receiving the payment.
>
> A physician may not accept payment of any kind, in any form, from any source, such as a pharmaceutical company or pharmacist, an optical company or the manufacturer of medical appliances and devices, for prescribing or referring a patient to said source for the purchase of drugs, glasses or appliances.
>
> In each case, the payment violates the requirement to deal honestly with patients and colleagues. The patient relies upon the advice of the physician on matters of referral. All referrals and prescriptions must be based on the skill and quality of the physician to whom the patient has been referred or the quality and efficacy of the drug or product prescribed. (Section 6.04,

CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, 1986)

Fee Splitting: Clinic or Laboratory Referrals. Clinics or laboratories that compensate physicians based solely on the amount of work referred by the physician to the clinic or laboratory are engaged in fee splitting which is unethical. (Section 6.05, CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, 1986)

Nevertheless, the legitimate division of income among members of a group is sanctioned in the Council's opinion that:

Fees: Group Practice. The division of income among members of a group, practicing jointly or in a partnership, may be determined by the members of the group and may be based on the value of the professional medical services performed by the member and his other services and contributions to the group. (Section 6.03, CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, 1986)

RECOMMENDATION III:

REFERRALS SHOULD BE BASED UPON THE REFERRING PHYSICIAN'S CONFIDENCE IN THE COMPETENCE AND ABILITY OF THE INDIVIDUAL OR HEALTH CARE FACILITY'S ABILITY TO PERFORM THE SERVICES NEEDED BY THE PATIENT. WHEN SERVICES ARE PROVIDED BY MORE THAN ONE PHYSICIAN, EACH PHYSICIAN SHOULD SUBMIT HIS OWN BILL AND BE COMPENSATED SEPARATELY, IF POSSIBLE. IF THIS IS NOT POSSIBLE AND A FEE FOR SERVICES PERSONALLY RENDERED BY MORE THAN ONE PHYSICIAN IS TO BE DIVIDED, THE NATURE OF THE FINANCIAL ARRANGEMENT SHOULD BE MADE KNOWN TO THE PATIENT. PAYMENTS TO OR BY A PHYSICIAN FOR THE REFERRAL OF PATIENTS ARE IMPROPER. MERE REFERRAL DOES NOT CONSTITUTE A PROFESSIONAL SERVICE FOR WHICH A FEE MAY ETHICALLY BE CHARGED.

Example 4: Physician's income is related to referral of patients to or from a third party.

Discussion: Potential conflicts between the physician's own financial interest and his interest in the welfare of the patient can arise in every type of medical practice arrangement. In some instances a physician's income may be enhanced by increasing the number of referrals he makes to a third party. For example, a physician might be a partial owner of a health facility to which he refers patients. If a physician's income from his partial ownership of the health facility is based on a percent of the profits rather than a return on investment based upon capital contributions, there is the appearance of impropriety on the part of the referring physician. Similarly, a physician might lease equipment or space to another physician to whom he refers patients and receive a percentage of the

profits as rental. If the rental does not represent the fair market value of the use of equipment or space, there is an appearance of impropriety on the part of the referring physician as well as an issue of fee splitting with respect to the physician who pays an excessive rent.

The Council on Ethical and Judicial Affairs has previously stated its belief that physicians are not entitled to derive a profit that results from services provided by the hospital under DRG payments. Also, certain types of joint venture activities include "risk-sharing" or "incentive" features under which attending physicians whose care of patients results in hospital costs that fall short of the applicable DRG amount under the Medicare prospective payment system share in the "profits." In these arrangements, the hospital usually pays a percentage of its excess DRG payment to the attending physician directly or credits a like amount to a special account maintained on behalf of the physician group that is its partner in the joint venture. (See Judicial Council Report D, I-84, "Ethical Implications of Hospital-Physician Risk-Sharing Arrangements under Diagnosis-Related Groups System.")

In addition to possible violations of state fee splitting statutes, the Medicare and Medicaid antifraud and abuse statutes prohibit the knowing and willful solicitation, receipt, offer or payment of any remuneration in return for the party furnishing referrals. Remuneration includes kickbacks, bribes, and rebates given or accepted in cash or in kind, directly or indirectly, overtly or covertly. The statutory language indicates Congress's intent to include practices that the federal government believed were causing unnecessary utilization and costing billions of dollars for unnecessary services and fraudulent claims.

A number of decisions indicate that the U.S. Department of Health and Human Services (HHS) and the courts interpret these statutes broadly. The most recent decision, United States v. Greber, 760 F.2d 68 (3d Cir. 1985), concerned a cardiologist whose company, Cardio-Med, Inc., provided physicians with diagnostic services. At issue in this case was the Holter-monitor service provided. Cardio-Med billed Medicare for the monitor service and forwarded a portion (40 percent but not to exceed $65.00 per patient) of the payment received to the referring physician. The fees were described as payment for the referring physician to explain the results to the patients. There was evidence that the referring physicians received their payments even though the cardiologist actually evaluated the Holter-monitor results. The court found that, according to the language and purpose of the statute, if the payments to the referring physicians were intended to induce those physicians to use Cardio-Med's services, the statute was violated, even if the payments were also intended to compensate for professional services.

RECOMMENDATION IV:

WHERE A PHYSICIAN'S INCOME MAY BE ENHANCED BY REFERRALS TO AN ENTITY IN WHICH HE HAS AN OWNERSHIP INTEREST, INCOME GENERATION SHOULD BE SEPARATE FROM VOLUME OF REFERRALS OR UTILIZATION. ALTERNATIVES MIGHT INCLUDE CORPORATE STRUCTURES WHERE: (1) RETURN ON EQUITY IS A FIXED OR INDEPENDENTLY DETERMINED RATIO REFLECTING CAPITALIZATION RATHER THAN INDIVIDUAL PROFESSIONAL REFERRALS; (2) MANAGEMENT AND PROFESSIONAL ENTITIES ARE SEPARATE; AND/OR (3) THERE IS INDEPENDENT UTILIZATION REVIEW, CONCURRENTLY OR RETROSPECTIVELY. SUCH MECHANISMS MIGHT HELP TO ASSURE (1) THAT INCOME IS NOT RELATED TO THE NUMBER OF REFERRALS OR THE REVENUE GENERATED BY THE PHYSICIAN OWNER OR INVESTOR BUT, INSTEAD, TO OWNERSHIP AND EQUITY CONSIDERATIONS; (2) THAT REFERRALS ARE MADE FOR MEDICALLY NECESSARY SERVICES; AND (3) THAT CHARGES ARE NOT EXCESSIVE.

On the other hand, a physician's income may be enhanced by decreasing the number of referrals he makes. For example, a physician might serve as a primary care case manager who is responsible for coordinating and controlling access to other health services needed by the patient. The primary care case manager is often placed at financial risk for the cost of care he orders. As noted by the Council on Medical Service in its report on "The Concept of a 'Gatekeeper'" that was adopted by the House of Delegates at its 1986 Annual Meeting, "...the physician providing 'gatekeeper' or primary care case management services is entitled to charge an appropriate fee for such services." (Council on Medical Service Rep. I, A-86).

The Council on Medical Service noted the following potential advantages unique to the "gatekeeper" approach: (1) stronger incentives toward prudent use of resources; and (2) the elimination of duplicative services. The Council also noted the following potential disadvantages unique to the "gatekeeper" approach: (1) an incentive to underserve patients; (2) possible delays in obtaining needed secondary or tertiary services; and (3) the provision of such services by less qualified practitioners, as well as restrictions on the patient's freedom of choice of the specialized provider.

The American Medical Association is committed to free market competition among various health care delivery systems, with the growth of each determined by the number of persons who prefer that mode of delivery.

The Council on Ethical and Judicial Affairs has stated:

Contractual Relationships. The contractual relationships that physicians assume when they enter prepaid group practice plans are varied.

Income arrangements may include hourly wages for physicians working part time, annual salaries for those working full time, and share of group income for physicians who are partners in groups that are somewhat autonomous and contract with plans to provide the required medical care. Arrangements also usually include a range of fringe benefits, such as paid vacations, insurance and pension plans.

Physicians may work directly for plans or may be employed by the medical group or the hospital that has contracted with the plan to provide services. The AMA recognizes that under proper legal authority such plans may be established and that a physician may be employed by, or otherwise serve, a medical care plan. In the operation of such plans, physicians should not be subjected to lay interference in professional medical matters and their primary responsibility should be to the patients they serve. (Section 8.05, CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, 1986)

Referral of Patients-Disclosure of Limitations. When a physician agrees to provide treatment, he thereby enters into a contractual relationship and assumes an ethical obligation to treat the patient to the best of his ability. PPO and HMO contracts generally restrict the participating physician's scope of referral to medical specialists, diagnostic laboratories, and hospitals that have contractual arrangements with the PPO or HMO. Some plans also restrict the circumstances under which referrals may be made to contracting medical specialists. If the PPO or HMO does not permit referral to a noncontracting medical specialist or to a diagnostic or treatment facility when the physician believes that the patient's condition requires such services, the physician should so inform the patient so that the patient may decide whether to accept the outside referral at his own expense or confine himself to services available within the PPO or HMO. In determining whether treatment or diagnosis requires referral to outside specialty services, the physician should be guided by standards of good medical practice. (Section 8.12, CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, 1986)

RECOMMENDATION V:

IT IS UNETHICAL TO INTENTIONALLY LIMIT UTILIZATION OF NEEDED MEDICAL SERVICES TO THE DETRIMENT OF A PATIENT FOR THE PHYSICIAN'S OWN PROFIT. IF A THIRD PARTY LIMITS A PATIENT'S ACCESS TO NECESSARY MEDICAL SERVICES CONTRARY TO STANDARD MEDICAL PRACTICE, THE PHYSICIAN SHOULD SO INFORM THE PATIENT AND PROTEST THE LIMITATION.

- CONCLUSION -

Financial rewards to physicians for the referral of patients or for failing to refer patients for necessary medical services can have, at least, the appearance of impropriety and can undermine the public's confidence in the medical profession. Medical decisions made solely on the basis of financially benefiting the physician are improper. The overriding principle is that conflicts between the physician's financial interest and the patient's medical interest must always be resolved to the benefit of the patient. Where the conflict is so great that the patient's interest is not served, the physician must cede the care of the patient to another qualified physician.

The trust and dependence reposited in the physician by the patient invokes an ethical obligation on the part of the physician far greater than that of the commercial purveyor of services. The obligation of the physician is to be an advocate for the patient. A physician must exercise medical judgment independently of his own or a third party's financial interests. No motive should be allowed to prevail against the physician's fundamental role of alleviating the suffering of his patients. If a third party attempts to corrupt the physician's exercise of medical judgment on behalf of his patients, the physician must be the advocate of the patient and vigorously oppose those who are adverse to the medical interests of the patient. If the physician's own interests are adverse to the patient's interests, alternative arrangements must be made for the care of the patient. The physician must never assume a position adverse to the interests of the patient.

The Council on Ethical and Judicial Affairs recommends that this report be filed.

APPENDIX

The following references to selected state statutes and opinions of state attorneys general are provided as illustrations of various public policy approaches. This is not intended as a comprehensive review of the law on these subjects. It is recommended that the current law of the jurisdiction be consulted.

[1]Florida statutes provide that the following are grounds for disciplinary action:

> "Exercising influence on the patient or client in such a manner as to exploit the patient or client for financial gain of the [physician] or of a third party which shall include, but not be limited to, the promoting or selling of services, goods, appliances, or drugs and the promoting or advertising on any prescription form of a community pharmacy unless the form shall also state 'this prescription may be filled at any pharmacy of your choice'." FLA. STAT. ANN. §458.331(1)(o) (West 1981).

An Illinois statute provides that the "Promotion of the sale of drugs, devices, appliances or goods provided for a patient in such manner as to exploit the patient for financial gain of the physician" is a basis for disciplinary action. ILL. STAT. ANN. Ch.111, §4433 (18) (Smith-Hurd 1986).

A Missouri attorney general's opinion indicates that "A physician who requires that his patient accept drugs dispensed by the physician and refuses to provide the patient a prescription for such drugs which can be filled at a pharmacy of the patient's choice may be in violation of the Missouri Antitrust Law and [the section stating grounds for denial, revocation or suspension of physicians' licenses]." Op. Att'y. Gen. No. 6, (July 8, 1982).

Rhode Island defines "unprofessional conduct" to include "promotion by a physician...of the sale of drugs, devices, appliances, or goods or services provided for a patient in such manner as to exploit the patient for the financial gain of the physician." R.I. GEN. LAWS §5-37.1-5(6) (1985).

A Texas statute provides that a licensed physician "is authorized to supply the needs of his patients with any drugs or remedies as are necessary to meet the patients' immediate needs" but a physician is not permitted "to operate a retail pharmacy without first complying with the Texas Pharmacy Act." An exception is permitted for "A licensed physician who practices medicine in a rural area in which there is no pharmacy" to "maintain a supply of dangerous drugs..." TEX. STAT. ANN. art. 4495(b) §5.09 (Vernon 1986).

A Virginia statute provides that the following constitutes unprofessional conduct:

> Being a practitioner of the healing arts who may lawfully dispense, administer, or prescribe, medicines or drugs, and not being the holder of a certificate of registration to practice pharmacy, engages in selling medicine, drugs, eyeglasses, or medical appliances or devices to persons who are not his own patients, or sells such articles to his own patients either for his own convenience, or for the purpose of supplementing his income; provided, however, that the dispensing of contact lenses by a practitioner to his patients shall not be deemed to be for the practitioner's own convenience or for the purpose of supplementing his income. VA. CODE §54-317(12) (1985).

In addition, the Virginia State Board of Medicine "shall have authority to promulgate rules and regulations regulating the sale of vitamins or food supplements by any practitioner of the healing arts from the office in which he practices." VA. CODE §54-278.2 (1985).

[2]California provides a detailed statutory scheme of regulation. Section 650 of the California Business and Professions Code provides that:

> Except as provided [in the sections of the Health and Safety Code relating to referral agencies] and in Section 654.1 it shall not be unlawful for any person licensed under this division to refer a person to any laboratory, pharmacy, clinic, or health care facility solely because such licensee has a proprietary interest or co-ownership in such laboratory, pharmacy, clinic, or health care facility; but such referral shall be unlawful if the prosecutor proves that there was no valid medical need for such referral."

It is the California attorney general's opinion that physicians may refer patients to clinical laboratories in which they have limited partnership interests without violating the prohibition on rebates and kickbacks if the physician informs patients (in writing) of that interest and that they are free to choose another laboratory to have the work performed. There is a valid medical need for the referral, and the physician's return on his or her investment is not measured by the number or value of his or her referrals. Op. Att'y. Gen. No. 84-806 (Feb. 8, 1985). Another California attorney general's opinion states that the provision of "professional courtesy services" by clinical laboratories to a physician or his family or to his physician-patients or their families violates this section only where such services are provided as compensation or inducement for referring patients to the clinical laboratory. Ops. Att'y. Gen. No. 79-920 (Feb. 8, 1980).

Section 654.2 of the California Business and Professions Code makes it unlawful for a physician:

(a)...to charge, bill, or otherwise solicit payment from a patient on behalf of, or refer a patient to, an organization in which the licensee, or the licensee's immediate family, has a significant beneficial interest, unless the licensee first discloses in writing to the patient that there is such an interest and advises the patient that...the patient may choose any organization for the purpose of obtaining the services ordered or requested by the [physician].

(b) The disclosure requirements of subdivision (a) may be met by posting a conspicuous sign in an area which is likely to be seen by all patients who use the facility or by providing those patients with a written disclosure statement. Where referrals, billings, or other solicitations are between licensees who contract with multispecialty clinics pursuant to subdivision (1) of Section 1206 of the Health and Safety Code or who conduct their practice as members of the same professional corporation or partnership, and the services are rendered on the same physical premises, or under the same professional corporation or partnership name, the requirements of subdivision (a) may be met by posting a conspicuous disclosure statement at a single location which is a common area or registration area or by providing those patients with a written disclosure statement...

(c) For the purposes of this section, the following terms have the following meanings:

(1) "Immediate family" includes the spouse and children of the licensee, the parents of the licensee and licensee's spouse, and the spouses of the children of the licensee.

(2) "Significant beneficial interest" means any financial interest that is equal to or greater than the lesser of the following:

(A) Five percent of the whole.

(B) Five thousand dollars ($5,000).

(d) This section shall not apply to a "significant beneficial interest" which is limited to ownership of a building where the space is leased to the organization at the prevailing rate under a straight lease agreement or to any interest held in publicly traded stocks.

(e)(1) This section does not prohibit the acceptance of evaluation specimens for proficiency testing or referral of specimens or assignment from one clinical laboratory to another clinical laboratory, either licensed or exempt under this chapter, if the report indicates clearly the name of the laboratory performing the test.

The statute does not apply if the physician, organization, or entity is providing or arranging for health care services pursuant to a prepaid capitated contract with the California State Department of Health Services.

However, Section 650.1 provides that:

> "any amount payable to...any person [licensed under the medical practice act] or corporation prohibited from pharmacy permit ownership...under any rental lease or service arrangement with respect to the furnishing or supply of pharmaceutical services and products, which is determined as a percentage, fraction, or portion of (1) the charges to patients or of (2) any measure of...pharmacy revenue or cost, for pharmaceuticals and pharmaceutical services is prohibited.

Section 654 provides that licensed physicians "may not have any membership, proprietary interest or ownership in any form in or with any person licensed [as an optician] to whom patients, clients or customers are referred or any profit-sharing interests."

Section 654.1 provides that licensed physicians "may not refer patients, clients, or customers to any clinical laboratory in...which the licensee has any membership, proprietary interest, or co-ownership in any form, or has any profit-sharing arrangement, unless the licensee at the time of making such referral discloses in writing such interest to the patient, client, or customer. The written disclosure shall indicate that the patient may choose any clinical laboratory for purposes of having any laboratory work or assignment performed." This section does not apply (1) to persons who are members of a medical group which contracts to provide medical care to members of a group practice prepayment plan registered under the Knox-Keene Health Care Service Act of 1975; (2) to any referral to a clinical laboratory which is owned and operated by a licensed health facility and (3) to the acceptance of evaluation specimens for proficiency testing or referral of specimens or such assignment from one clinical laboratory to another if the report indicates clearly the laboratory performing the test. Also, "proprietary interest" does not include ownership of a building where space is leased to a clinical laboratory at the prevailing rate under a straight lease arrangement.

Florida provides that the following is a ground for disciplinary action and a misdemeanor punishable by a year in prison and/or a $1,000 fine for osteopathic physicians:

> Referring any patient, for health care goods or services, to any partnership, firm, corporation, or other business entity in which the physician or the physician's employer has an equity interest of 10 percent or more, unless prior to such referral, the physician notifies the patient of his financial interest and of

the patient's right to obtain such goods or services at the location of the patient's choice. This section shall not apply to the following types of equity interests.

1. The ownership of registered securities issued by a publicly held corporation or the ownership of securities issued by a publicly held corporation, the shares of which are traded on a national exchange or the over the counter market;

2. A physician's own practice, whether the physician is a sole practitioner or part of a group, when the health care good or service is prescribed or provided solely for the physician's own patients and is provided or performed by the physician or under the physician's supervision; or

3. An interest in real property resulting in a landlord-tenant relationship between the physician and the entity in which the equity interest is held, unless the rent is determined, in whole or in part, by the business volume or profitability of the tenant, or is otherwise unrelated to fair market value. 1986 FL. SESS. LAW SERV. 86-290 (West). (to be codified at FL. STAT. §459.013 (3)(b)).

Also, "It shall be a misdemeanor of the first degree...for any health care practitioner...[to] provide medicinal drugs from any source other than on a complimentary basis when the practitioner has a financial interest or for which the practitioner will receive some financial remuneration, unless in advance of any such referral, the practitioner notifies the patient, in writing, of such financial interest." 1986 FL. SESS. LAW SERV. 86-31 (West) (to be codified at FL. STAT. §455.25).

A Michigan statute defines as unprofessional conduct: "Promotion for personal gain of an unnecessary drug, device, treatment, procedure, or service, or directing or requiring an individual to purchase or secure a drug, device, treatment, procedure, or service from another person, place, facility or business in which the licensee has a financial interest." MICH. STAT. ANN. §14.15 (16221)(e)(iii). A Michigan attorney general's opinion provides that violation of the prohibition against a licensed health professional having a financial interest in a clinical laboratory is not avoided by disclosure of the interest to the individual being directed or required to obtain a drug, device, treatment, procedure or service. Op. Att'y. Gen. No. 5498 (June 8, 1979). Further, the opinion provides that:

A licensed health professional is prohibited from directing or requiring an individual to purchase or secure a drug, device, treatment, procedure or service, even if necessary, from a person, place, facility or business in which the licensed health professional has a financial interest. A licensed health

> professional has a "financial interest" in a clinical laboratory if he or she is the proprietor, a partner, a limited partner, a shareholder, or has a similar business interest in the clinical laboratory. Ibid.

A Missouri Attorney General's opinion states that:

> "A physician who instructs or requires a patient to use a pharmacy in which the physician has a financial interest to fill a drug prescription may be in violation of the Missouri Antitrust Law and this section listing grounds for denial, revocation or suspension of physician's licenses. Op. Att'y. Gen. No. 6 (1982).

[3]Section 650 of the California Business and Professions Code provides:

> Except as provided...[with respect to licensed referral agencies,] the offer, delivery, receipt or acceptance, by any person licensed under this division of any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person, irrespective of any membership, proprietary interest or co-ownership in or with any person to whom such patients, clients or customers are referred unlawful...

An Illinois statute provides the following as grounds for disciplinary action: "Directly or indirectly giving to or receiving from any physician, person, firm or corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personnally rendered." However, this does not prohibit licensed physicians from practicing medicine in partnership under a partnership agreement or in an authorized corporation, professional association, or professional corporation, "or from pooling, sharing, dividing or apportioning the fees and monies received by them or by the partnership, corporation or association in accordance with the partnership agreement or the policies of the Board of Directors of the corporation or association." Nor does the statute prohibit two or more authorized corporations from "forming a partnership or joint venture of such corporations, and providing medical, surgical and scientific research and knowledge by employees of these corporations if such employees are licensed under this Act, or from pooling, sharing, dividing, or apportioning the fees and monies received by the partnership or joint venture in accordance with the partnership or joint venture agreement." Nor does the statute "abrogate the right of two or more persons holding valid and current licenses under this Act to receive adequate compensation for concurrently rendering professional services to a patient and divide a fee; provided, the patient has full knowledge of the division, and, provided, that the division is made in proportion to the services performed and

PHYSICIANS AS ENTREPRENEURS

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Physicians treating patients in need of nutritional support are being invited to enter into joint business ventures with pharmacies and home health agencies. Are joint ventures between physicians and medical suppliers or home health agencies ethical? Are they legal? The answer, not surprisingly, is: it depends.

It depends, in part, on the location of the proposed activities, because pharmacy and medical practice (and, to a lesser extent, home health care) are regulated by state law. The answer also depends on whether the patients to be served will be Medicare or Medicaid beneficiaries and, if so, whether physicians will be referring patients to a home health agency in which they have a financial interest. Finally, it will depend upon the specific arrangements contemplated, and the basis on which payments to the physicians will be made. I shall review the current debate on the ethical issues first, and then discuss some of the legal considerations.

ETHICAL ISSUES

The Debate

The traditional role of physicians has been a fiduciary one, based upon the expectation that their primary goal was the patient's best interest. With the emergence of what is now called the "health care industry," physicians are being enticed and invited into entrepreneurial activities. Some people, both within and outside the medical profession, have questioned the propriety of (1) physician ownership of health care businesses, and (2) referrals of patients to entities in which the referring practitioner has a financial interest.

Probably the most pointed debate on these issues occurred between two members of a committee empaneled by the National Academy of Sciences' Institute of Medicine. Discussions during the preparation of the Committee's 1986 report on "For-Profit Enterprise in Health Care" triggered a lively exchange of correspondence between Arnold Relman, editor of the *New England Journal of Medicine*, and Uwe Reinhardt, professor of political economy at Princeton University.[1] (The correspondence is reprinted in its entirety in the Summer 1986 issue of *Health Affairs*.)[2]

The initial question is whether, as Relman puts it, the public appropriately expects health care providers to behave differently from the purveyors of other goods and services. Relman argues that the relationship of trust between physician and patient, together with the "virtually total dependence of the consumer on the advice of the physician, and the often intimate and immediate relation of health care to the quality and quantity of life" distinguish the profession of medicine from other services.[3] Reinhardt, on the other hand, believes that in demanding payment for services at the time of an office visit, or even in advance (as is often the case for surgery), physicians lead their patients to view them as regular business persons.[4] Chiding Relman for his belief that physicians are somehow ethically superior, Reinhardt counters:

> Sometimes you seem to suggest that physicians are endowed with a strong commitment to ethical conduct. If that is true, why do you worry so? At other times you lament the erosion of medical ethics in the face of capitalist medicine. If medical ethics erode so easily, what then does set physicians apart from "other purveyors"?[5]

Even assuming that one believes physicians should hold to a standard a little higher than marketplace

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morality, the important question is how that should translate into what is permissible and what is prohibited.

The AMA Position

Section 6.03 of the 1984 *Current Opinions of the Judicial Council of the American Medical Association* forbids acceptance by physicians of "payment of any kind, in any form, from any source" for prescribing or referring a patient to a particular source of drugs, eye glasses, or medical appliances. Other Sections (4.04 and 8.06) permitted physician ownership of health care facilities and pharmacies, but warned against exploitation, advised that physicians have a duty to disclose ownership of a health facility to their patients, and emphasized that patients are entitled to free choice in selection of pharmacies.

The Judicial Council issued more specific guidance on the matter of joint ventures in 1985, noting first that conflicts may arise when physicians derive economic benefits from commercial ventures involving their patients.[6] The Council found nothing objectionable per se in physicians entering into lawful contractual relationships, including the acquisition of financial interests in health facilities and suppliers of medical equipment or pharmaceuticals.

The Council cautioned, however, that in view of potential conflicts of interest, the following principles should be observed:

1. The physician has an affirmative ethical obligation to disclose to the patient or referring colleagues his or her ownership interest in the facility or therapy prior to utilization;
2. The physician may not exploit the patient in any way, as by inappropriate or unnecessary utilization;
3. The physician's activities must be in strict conformance with the law;
4. The patient should have free choice either to use the physician's proprietary facility or therapy or to seek the needed medical services elsewhere; and
5. When a physician's commercial interest conflicts so greatly with the patient's interest as to be incompatible, the physician should make alternative arrangements for the care of the patient.[7]

It is significant that the statement just quoted was an expansion of a more modest version, published only a year earlier.

As will be evident from the discussion to follow, the views expressed by the AMA Judicial Council have been reflected in many state laws governing the practice of medicine and pharmacy.

LEGAL ISSUES

Variations among State Pharmacy and Medical Practice Laws

The extent to which physicians are permitted to own financial interests in health care businesses, and to refer patients to entities in which they have such an interest, varies considerably among the states. As noted earlier, the practice of medicine and pharmacy is governed primarily by state law. (Retail pharmacies, operating in conformity with state laws, are exempt from federal regulations governing the manufacture and distribution of prescription drugs and devices.)[8]

It is beyond the scope of this article to provide a state-by-state analysis, and such an effort would be of questionable value, in any event, because state laws are changing in response to shifting public attitudes. Suffice it to say that state regulation ranges from a total prohibition of physician ownership in pharmacies (as in California) to no restrictions on such ownership, and from total prohibition of physician referrals to businesses in which they have a financial interest (as in Michigan) to no limitations on such referrals.[9] Most states are in the middle range of regulation, requiring disclosure of ownership and/or a "freedom of choice" notice to patients.

At least some of the states that restrict business arrangements between physicians and other health care providers appear to be serious about enforcement. In California, for example, a state appellate court upheld the law forbidding physician ownership of pharmacies, emphasizing the public policy concerns reflected in the legislative history.[10] The California court made clear that, although physicians are prohibited from pharmacy ownership as individuals or as members of partnerships, the relevant statute permitted them to own shares in a pharmacy corporation. (Subsequent amendments to the California law limit physician ownership in such corporations to 10%.)

In Michigan, although physicians are permitted to have an ownership interest in businesses furnishing health care services and supplies, they are prohibited from referring patients to entities in which they have such an interest. The Michigan law defining unprofessional conduct on the part of a physician forbids:

> Promotion for personal gain of an unnecessary drug, device, treatment, procedure or service, or *directing* or requiring *an individual to purchase or secure a drug, device, treatment, procedure, or service from another person, place, facility, or business in which the [physician] has a financial interest.*[11]

A 1979 opinion of the Michigan Attorney General made clear that:

1. A physician has a "financial interest" in an entity if he or she is the proprietor, a partner, a limited partner, a shareholder, or has a similar business interest in the [entity];
2. Referrals to entities in which the physician has a financial interest are prohibited even if the drugs, devices, etc. furnished by that entity are genuinely necessary for treating the patient's condition; and
3. Disclosure to patients of the financial interest does not cure the violation of law.[12]

A Michigan circuit court upheld the constitutionality of the anti-referral law in 1982, rejecting the claim of two physicians that the prohibition against "directing" patients to entities was unacceptably vague and ambiguous.[13]

California and Michigan are examples of unusually strict state regulation. Most states have adopted one or more of the following provisions: (1) that a physician must disclose ownership interest in a health care entity at the time a referral is made,[14] (2) that physicians may not use prescription pads bearing the name or logo of a particular pharmacy or supplier,[15] or (3) that patients must be informed of their right to have prescriptions filled by the pharmacy of their choice.[16]

Some state laws simply have general prohibitions against exploiting patients for personal gain or engaging in unethical practices. These vague provisions, however, may be interpreted by the staff, counsel, or members of the state professional licensing Board as requiring disclosure of the physician's financial interest or of the patient's "freedom of choice" (or both).[17] As a result, even in states having no explicit statutory restrictions, the manner in which licensing boards interpret and apply the law may achieve a similar result.

Federal and State Anti-Kickback Provisions

The federal anti-fraud and abuse provisions prohibit the knowing and willful solicitation, payment, offer or acceptance of remuneration of any kind, direct or indirect, in return for referrals for health care goods or services for which payment will be made by Medicare or Medicaid.[18] Recent court cases and Medicare Intermediary Letters make clear that outright kickbacks are not the only arrangements prohibited; also considered potentially illegal are arrangements to pay referring practitioners a fee for their services related to the amount of business referred. Even special discounts not available to other purchasers who do not refer patients may be unlawful.

In a recent case, *U.S. v. Greber*, a U.S. Court of Appeals ruled that payments to physicians for professional consultation, "if . . . intended to induce the physicians to use [defendant's] services," violated the federal anti-kickback provisions "even if the payments were also intended to compensate for professional services."[19] (The financial arrangements in *Greber* were flagrant abuses, however.)

The U.S. Department of Health and Human Services (HHS) also has taken a broad view of the kinds of business arrangements that may violate the anti-fraud and abuse provisions,[20] and it is now clear that both courts and administrative agencies will look behind such labels as "consultant" or "handling" fees to the true nature of a business relationship in determining whether payments between practitioners and other providers of health services are in violation of the law.

Entering into joint ventures with the understanding that no Medicare or Medicaid patients will be treated (or referred) under the agreement will not necessarily solve the problem, because many states have adopted their own version of the federal anti-kickback law to cover all patients.

Nevertheless, it is possible to structure joint ventures between physicians and other health care providers or suppliers in legitimate ways that avoid violating the prohibitions of state and federal law. What it requires is considerable care and legal expertise.

Certification of a Patient's Need for Home Health Services under Medicare

Federal regulations governing the participation of home health agencies in Medicare were recently amended to limit further the extent to which physicians may refer patients to home health agencies in which they have a financial interest, as required by the Omnibus Reconciliation Act of 1980 and the Deficit Reduction Act of 1984.[21] It is now unlawful for a physician to certify a patient's need for home health services if those services will be provided by an agency in which the certifying physician has an ownership interest in the capital, stock, or profits of 5% or more, or with which the physician has a significant financial or contractual relationship.[22]

Under the new rules, a "significant financial or contractual relationship" is defined as one in which the physician:

(i) [r]eceives any compensation as an officer or director of the HHA (home health agency);
(ii) has direct or indirect business transactions with the HHA that, in any fiscal year, amount to more

than $25,000 or 5% of the agency's total operating expenses, whichever is less. Business transactions means contracts, agreements, purchase orders, or leases to obtain services, supplies, equipment, and space and, after August 29, 1986, salaried employment.[23]

The limitations described above do not apply in the case of an entity classified by the Health Care Financing Administration as a sole community home health agency.[24] Unless a home health agency has received such a classification, however, a physician having more than a 5% ownership interest in, or a significant business relationship with, a home health agency may not certify—or recertify—a patient's need for home health services to be provided by that agency.

PENALTIES FOR VIOLATION

Penalties for violation of the laws described above cover a broad range. Most Pharmacy and Medical Practice Acts provide for injunctions of illegal activities, as well as for fines and imprisonment (usually less than one year) for violations of those Acts, generally characterized as misdemeanors. They also provide for censure and suspension, revocation, or denial of the practitioner's license. Some states go even further. For example, Michigan recently enacted legislation imposing fines up to $50,000 and imprisonment for up to four years (or both) for conviction of violating the Michigan anti-kickback law.[25]

Persons convicted of violating the federal anti-kickback provisions are subject to loss of eligibility to participate in Medicare and Medicaid, as well as criminal prosecution with possible fines up to $25,000 and imprisonment for up to five years.[26] Although it may have seemed in the recent past that prosecution is unlikely, recent developments suggest that attitudes may be changing.

Private insurers have begun supplementing state and federal investigations, thus increasing the likelihood of enforcement activities. In a recent Washington, D.C., press conference, directors of seven Blue Cross and Blue Shield anti-fraud units described over 450 cases they have investigated and brought to prosecution over the last two years, often with assistance of federal agents.[27] Although most of the cases reported by Blue Cross for prosecution involved outright fraud (such as billing for services never performed), some practitioners have been convicted for performing unnecessary services on a large scale (identified by Blue Cross through computerized post-payment reviews).

In addition, the Blue Cross/Blue Shield Plans are seeking enactment of state laws providing for felony penalties for attempting to defraud health insurers. Such laws have passed in Michigan, Ohio, and Washington, and are being developed in additional states.[28]

In short, the efforts of private health insurers are resulting both in enhanced investigation and enforcement activities at the state and federal levels and in state laws with stiffer penalties, thus increasing the risk to practitioners who may be engaged in unlawful business practices. Although a practitioner always may fight an enforcement action, the cost of doing so may be high, both financially and in terms of adverse publicity.

CONCLUSIONS

The commercialization of health care has created both opportunities and incentives for joint ventures between physicians and other providers of health care services and supplies. At the same time, the proliferation of such business arrangements has provoked a spate of critical commentary and regulatory action. In light of the heightened scrutiny now focused on such transactions, physicians, pharmacies, and home health agencies contemplating joint ventures or similar business arrangements should obtain the advice of knowledgeable legal counsel and structure the arrangements so as to avoid the possible legal sanctions I have described.

References

1. Institute of Medicine. For-Profit Enterprise in Health Care, National Academy Press, Washington, 1986.
2. Relman A, Reinhardt U. Debating-for-Profit Health Care and the Ethics of Physicians. Health Affairs, 5–31, Summer 1986.
3. *Id.* at 18.
4. *Id.* at 10.
5. *Id.* at 22.
6. Reports of the Judicial Council of the American Medical Association, December 1984, JAMA 253(16): 2424-2425, April 26, 1985.
7. *Id.* at 2425.
8. 21 U.S.C. §§ 360(a) and (g) (1985).
9. Cal Bus. & Prof. Code § 4080.5 (Deering Supp. 1986); Mich. Comp. Laws Ann. § 333.16221(e)(iii) (West 1980 and Supp. 1984–85).
10. *Magan Medical Clinic v. California State Board of Medical Examiners*, 249 Cal. App. 2d 124, 57 Cal. Rptr. 256 (1957); *see esp. id.*, 57 Cal. Rptr. at 260–262.
11. Mich. Comp. Laws Ann. § 333.16221(e)(iii) West 1980 and Supp. 1984–85) (emphasis added).
12. Mich. Op. Atty. Gen. No. 5498 (June 8, 1979).
13. *Lester v. Kelly*, No. 79-189821-CZ (Circ. Ct. Oakland Co., Oct. 6, 1982).
14. *See, e.g.*, Ariz. Rev. Stat. Ann. § 32-1401 (dd) (West 1986); Cal. Busin. & Prof. Code § 654.2 (Deering Supp. 1986).
15. *See, e.g.*, N.Y. Admin. Code tit. 8, § 29.7(a)(12)(1984); Pa. Admin. Code § 27.18(q)(Shepard's 1984).

16. *See, e.g.*, Fla. Stat. Ann. § 458.331(o)(West 1981).
17. Personal communications with counsel, executive secretaries, and other staff of Medical Boards in a number of states.
18. 42 U.S.C. § 1395nn(b) (Medicare); 42 U.S.C. § 1396n(b) (Medicaid).
19. *U.S. v. Greber*, 760 F.2d 68, 72 (3d Circ. 1985); *see also, U.S. v. Lipkis*, 770 F.2d 1447 (9th Circ. 1985); *U.S. v. Hancock*, 604 F.2d 999 (7th Circ. 1979), *cert. denied*, 444 U.S. 991 (1979).
20. *See, e.g.* Medicare Part B Intermediary Letter 85-2 (April 1985), superceding Medicare Part B Intermediary Letter 84-9 (September 1984), advising that arrangements through which practitioners obtain an opportunity to generate fees by referring patients to medical suppliers may violate the federal anti-fraud and abuse law.
21. Pub. L. 96-499, § 930(e) and Pub. L. 98-369, § 2336, Amending Sections 1814(a) and 1835(a) of the Social Security Act, codified at 42 U.S.C. §§ 1102, 1395 f, m, and hh.
22. 51 *Fed. Reg.* 23541-23546, June 30, 1986, *to be codified at* 42 C.F.R. § 405.1633(d).
23. *Id.*, § 405.1633(d)(3).
24. *Id.*, § 405.1633(e).
25. Mich. Comp. Laws Ann. § 752.1004 (West Supp. 1986).
26. 42 U.S.C. §§ 1320a-7, 1395nn, and 1396h (1985).
27. Blue Cross and Blue Shield Association Press Release: Anti-fraud campaigns yield $51 million savings for Blue Cross and Blue Shield Plans, Dec. 10, 1986. [Contact: Charlotte Crenson, Blue Cross and Blue Shield Assoc., 1709 New York Avenue, N.W., Washington, D.C. 20006. (202) 783-6257.]
28. *Id.*

ercise of power of Congress to control ugs in commerce as to render invalid e Sanitary Code of the City of New ork, requiring disclosure of ingredients of patent medicines, and providing punishment for violation thereof. E. Fougera & Co. v. City of New York, 1918, 120 N.E. 642, 224 N.Y. 269, 1 A.L.R. 1467.

SUBCHAPTER II—DEFINITIONS

321. Definitions; generally

For the purposes of this chapter—

(a) (1) The term "State", except as used in the last sentence of ection 372(a) of this title, means any State or Territory of the Unitd States, the District of Columbia, and the Commonwealth of Puerto ico.

(2) The term "Territory" means any Territory or possession of the Jnited States, including the District of Columbia, and excluding the Commonwealth of Puerto Rico and the Canal Zone.

(b) The term "interstate commerce" means (1) commerce between ny State or Territory and any place outside thereof, and (2) commerce within the District of Columbia or within any other Territory ot organized with a legislative body.

(c) The term "Department" means the Department of Health, Education, and Welfare.

(d) The term "Secretary" means the Secretary of Health, Education, and Welfare.

(e) The term "person" includes individual, partnership, corporation, nd association.

(f) The term "food" means (1) articles used for food or drink for nan or other animals, (2) chewing gum, and (3) articles used for omponents of any such article.

(g) (1) The term "drug" means (A) articles recognized in the offiial United States Pharmacopoeia, official Homoeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them; and (B) articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals; and (C) articles (other than food) intended to affect the structure or any function of the body of man or other animals; and (D) articles intended for use as a component of any article specified in clauses (A), (B), or (C) of this paragraph; but does not include devices or their components, parts, or accessories.

(2) The term "counterfeit drug" means a drug which, or the container or labeling of which, without authorization, bears the trademark, trade name, or other identifying mark, imprint, or device, or any likeness thereof, of a drug manufacturer, processor, packer, or

distributor other than the person or persons who in fact manufactured, processed, packed, or distributed such drug and which thereby falsely purports or is represented to be the product of, or to have been packed or distributed by, such other drug manufacturer, processor, packer, or distributor.

(h) The term "device" (except when used in paragraph (n) of this section and in sections 331(i), 343(f), 352(c), and 362(c) of this title) means instruments, apparatus, and contrivances, including their components, parts, and accessories, intended (1) for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals; or (2) to affect the structure or any function of the body of man or other animals.

(i) The term "cosmetic" means (1) articles intended to be rubbed, poured, sprinkled, or sprayed on, introduced into, or otherwise applied to the human body or any part thereof for cleansing, beautifying, promoting attractiveness, or altering the appearance, and (2) articles intended for use as a component of any such articles; except that such term shall not include soap.

(j) The term "official compendium" means the official United States Pharmacopoeia, official Homoeopathic Pharmacopoeia of the United States, official National Formulary, or any supplement to any of them.

(k) The term "label" means a display of written, printed, or graphic matter upon the immediate container of any article; and a requirement made by or under authority of this chapter that any word, statement, or other information appear on the label shall not be considered to be complied with unless such word, statement, or other information also appears on the outside container or wrapper, if any there be, of the retail package of such article, or is easily legible through the outside container or wrapper.

(l) The term "immediate container" does not include package liners.

(m) The term "labeling" means all labels and other written, printed, or graphic matter (1) upon any article or any of its containers or wrappers, or (2) accompanying such article.

(n) If an article is alleged to be misbranded because the labeling is misleading, then in determining whether the labeling is misleading there shall be taken into account (among other things) not only representations made or suggested by statement, word, design, device, or any combination thereof, but also the extent to which the labeling fails to reveal facts material in the light of such representations or material with respect to consequences which may result from the use of the article to which the labeling relates under the conditions of use prescribed in the labeling thereof or under such conditions of use as are customary or usual.

(h) The term "device" (except when used in paragraph (n) of this section and in sections 331(i), 343(f), 352(c), and 362(c) of this title) means an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is—

(1) recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them,

(2) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or

(3) intended to affect the structure or any function of the body of man or other animals, and

which does not achieve any of its principal intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of any of its principal intended purposes.

[See main volume for text of (i) to (m)]

(n) If an article is alleged to be misbranded because the labeling or advertising is misleading, then in determining whether the labeling or advertising is misleading there shall be taken into account (among other things) not only representations made or suggested by statement, word, design, device, or any combination thereof, but also the extent to which the labeling or advertising fails to reveal facts material in the light of such representations or material with respect to consequences which may result from the use of the article to which the labeling or advertising relates under the conditions of use prescribed in the labeling or advertising thereof or under such conditions of use as are customary or usual.

[See main volume for text of (o) and (p)]

(q) The term "pesticide chemical" means any substance which, alone, in chemical combination or in formulation with one or more other substances, is "a pesticide" within the meaning of the Federal Insecticide, Fungicide, and Rodenticide Act [7 U.S.C.A. § 136 et seq.] as now in force or as hereafter amended, and which is used in the production, storage, or transportation of raw agricultural commodities.

[See main volume for text of (r) to (v)]

(w) The term "new animal drug" means any drug intended for use for animals other than man, including any drug intended for use in animal feed but not including such animal feed,—

[See main volume for text of (1)]

(2) the composition of which is such that such drug, as a result of investigations to determine its safety and effectiveness for use under such conditions, has become so recognized but which has not, otherwise than in such investigations, been used to a material extent or for a material time under such conditions.

[See main volume for text of (x)]

(y) The term "informal hearing" means a hearing which is not subject to section 554, 556, or 557 of Title 5 and which provides for the following:

(1) The presiding officer in the hearing shall be designated by the Secretary from officers and employees of the Department of Health, Education, and Welfare who have not participated in any action of the Secretary which is the subject of the hearing and who are not directly responsible to an officer or employee of the Department who has participated in any such action.

(2) Each party to the hearing shall have the right at all times to be advised and accompanied by an attorney.

(3) Before the hearing, each party to the hearing shall be given reasonable notice of the matters to be considered at the hearing, including a comprehensive statement of the basis for the action taken or proposed by the Secretary which is the subject of the hearing and a general summary of the information which will be presented by the Secretary at the hearing in support thereof.

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References in Text
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1980 Amendment
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Cross References

Disability insurance,
- Chiropractic services, reimbursement for cost of service, see § 20–1376.01.
- Psychiatric, drug abuse or alcoholism services, reimbursement for cost of service, see § 20–1376.

Group disability insurance,
- Chiropractic services, reimbursement for cost of service, see § 20–1406.01.
- Psychiatric, drug abuse or alcoholism services, reimbursement for cost of service, see § 20–1406.

Health care cost containment system administration,
- Home health services, see § 36–2907.
- Transplants and immunosuppressant medications, see § 36–2907.

Long-term care system, preadmission screening, see § 36–2936.

Subscription contract of hospital and medical service corporation,
- Chiropractic services, reimbursement for cost of service, see § 20–841.01.
- Psychiatric, drug abuse or alcoholism services, reimbursement for cost of service, see § 20–841.

ARTICLE 1. BOARD OF MEDICAL EXAMINERS

§ 32–1401. Definitions

In this chapter, unless the context otherwise requires:

1. "Active license" means a valid and subsisting license to practice medicine.

2. "Adequate records" means legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment.

3. "Approved hospital internship, residency or fellowship program" means that the applicant completed training at a time when the hospital in which the training occurred was legally incorporated and approved for internship, fellowship or residency training by the accreditation council for graduate medical education, the association of American medical colleges, the royal college of physicians and surgeons of Canada or any similar body in the United States or Canada approved by the board whose function is that of approving hospitals for internship, fellowship or residency training.

4. "Approved school of medicine" means any school or college offering a course of study which, upon successful completion, results in the degree of doctor of medicine and whose course of study has been approved or accredited by an educational or professional association, recognized by the board, including the association of American medical colleges, the association of Canadian medical colleges or the American medical association.

5. "Board" means the board of medical examiners of the state of Arizona.

6. "Doctor of medicine" means a natural person holding a license to practice medicine pursuant to this chapter.

7. "Health care institution" means any facility as defined in § 36–401 or any person authorized to transact disability insurance, as defined in title 20, chapter 6, article 4 or 5,[1] or any person who is issued a certificate of authority pursuant to title 20, chapter 4, article 9[2] or any other partnership, association or corporation which provides health care to consumers.

8. "Letter of concern" means an advisory letter to notify a physician that, while there is insufficient evidence to support disciplinary action, the board believes the physician should modify or eliminate certain practices and that continuation of the activities which led to the information being submitted to the board may result in action against the physician's license.

9. "Medically incompetent" means lacking in sufficient medical knowledge or skills, or both, to a degree likely to endanger the health of patients.

10. "Practice of medicine" means the diagnosis of, the treatment or the correction of or the attempt or the holding of oneself out as being able to diagnose, treat or correct any and all human diseases, injuries, ailments, infirmities, deformities, physical or mental, real

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11. "Special purpose licen national board of medical exa for use by state licensing boa are applying for licensure and in another jurisdiction and to by a state licensing board.

12. "Unprofessional condu state or elsewhere:

(a) Violation of any federa practice of medicine.

(b) Intentional betrayal of a communication except as eith

(c) False, fraudulent, decep medical services.

(d) Commission of a felony, or involving moral turpitude. jurisdiction or a plea of no co:

(e) Failing or refusing to m: to make such records promptly proper authorization.

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(*l*) Conduct that the board malpractice or negligence or a patient.

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(q) Any conduct or practice v the patient or the public.

or imaginary, by any means, methods, devices or instrumentalities, except as the same may be among the acts or persons not affected by this chapter. The practice of medicine includes the practice of medicine alone or the practice of surgery alone, or both.

11. "Special purpose licensing examination" means an examination developed by the national board of medical examiners on behalf of the federation of state medical boards for use by state licensing boards to test the basic medical competence of physicians who are applying for licensure and who have been in practice for a considerable period of time in another jurisdiction and to determine the competence of a physician under investigation by a state licensing board.

12. "Unprofessional conduct" includes the following acts, whether occurring in this state or elsewhere:

(a) Violation of any federal or state laws or rules and regulations applicable to the practice of medicine.

(b) Intentional betrayal of a professional secret or intentional violation of a privileged communication except as either act may otherwise be required by law.

(c) False, fraudulent, deceptive or misleading advertising or advertising the quality of medical services.

(d) Commission of a felony, whether or not involving moral turpitude, or a misdemeanor involving moral turpitude. In either case, conviction by any court of competent jurisdiction or a plea of no contest is conclusive evidence of the commission.

(e) Failing or refusing to maintain adequate records on a patient or failing or refusing to make such records promptly available to another physician upon request and receipt of proper authorization.

(f) Habitual intemperance in the use of alcohol or habitual substance abuse.

(g) Use of controlled substances except if prescribed by another physician for use during a prescribed course of treatment.

(h) Prescribing or dispensing controlled substances to members of the physician's immediate family.

(i) Prescribing, dispensing or administering schedule II controlled substances as defined in § 36-2513 including amphetamines and similar schedule II sympathomimetic drugs in the treatment of exogenous obesity for a period in excess of thirty days in any one year, or the non-therapeutic use of injectable amphetamines.

(j) Prescribing, dispensing or administering any controlled substance or prescription-only drug for other than accepted therapeutic purposes.

(k) Signing a blank, undated or predated prescription form.

(*l*) Conduct that the board determines is gross malpractice or negligence, repeated malpractice or negligence or any malpractice or negligence resulting in the death of a patient.

(m) Representing that a manifestly incurable disease or infirmity can be permanently cured, or that any disease, ailment or infirmity can be cured by a secret method, procedure, treatment, medicine or device, if such is not the fact.

(n) Refusing to divulge to the board upon demand the means, method, procedure, modality of treatment or medicine used in the treatment of a disease, injury, ailment or infirmity.

(*o*) Refusal, revocation, suspension, limitation or restriction of a license by any other licensing jurisdiction for inability to safely and skillfully practice medicine or for unprofessional conduct as defined by that jurisdiction which directly or indirectly corresponds to any act of unprofessional conduct as prescribed by this paragraph.

(p) Sanctions including restriction, suspension or removal from practice imposed by an agency of the federal government.

(q) Any conduct or practice which is or might be harmful or dangerous to the health of the patient or the public.

(r) Violation of a formal order, probation or stipulation issued by the board under the provisions of this chapter.

(s) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate any provision of this chapter.

(t) Knowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine.

(u) Charging a fee for services not rendered or dividing a professional fee for patient referrals.

(v) Obtaining a fee by fraud, deceit or misrepresentation.

(w) Charging or collecting a clearly excessive fee. In determining the reasonableness of a fee, the fee customarily charged in the state for similar services shall be considered in light of modifying factors, such as the time required, the complexity of the service and the skill requisite to perform the service properly. This subdivision does not apply if there is a clear written contract for a fixed fee between the physician and the patient which has been entered into prior to the provision of service.

(x) Fetal experiments conducted in violation of § 36-2302.

(y) The use of experimental forms of diagnosis and treatment without adequate informed patient consent, and without conforming to generally accepted experimental criteria, including protocols, detailed records, periodic analysis of results and periodic review by a peer review committee.

(z) Sexual intimacies with a patient in the course of direct treatment.

(aa) Procuring or attempting to procure a license to practice medicine or a license renewal by fraud, by misrepresentation or by knowingly taking advantage of the mistake of another person or an agency.

(bb) Representing or holding oneself out as being a medical specialist when such is not the fact.

(cc) Maintaining a professional connection with or lending one's name to enhance or continue the activities of an illegal practitioner of medicine.

(dd) Failing to furnish information in a timely manner to the board or its investigators or representatives if legally requested by the board.

(ee) Failing to allow properly authorized board personnel on demand to examine and have access to documents, reports and records maintained by the physician that relate to his medical practice or medically related activities.

(ff) Knowingly failing to disclose to a patient on a form prescribed by the board which is dated and signed by the patient or guardian acknowledging that the patient or guardian has read and understands that the doctor has a direct pecuniary interest in a separate diagnostic or treatment agency or in non-routine goods or services which the patient is being prescribed and if the prescribed treatment, goods or services are available on a competitive basis. This subdivision does not apply to a referral by one doctor of medicine to another doctor of medicine within a group of doctors of medicine practicing together.

(gg) Using chelation therapy in the treatment of arteriosclerosis or as any other form of therapy, with the exception of treatment of heavy metal poisoning, without adequate informed patient consent and without conforming to generally accepted experimental criteria, including protocols, detailed records, periodic analysis of results and periodic review by a peer review committee.

(hh) Prescribing, dispensing or administering anabolic-androgenic steroids to a person for other than therapeutic purposes.

(ii) Lack of or inappropriate direction, collaboration or supervision of a licensed, certified or registered health care provider employed by or assigned to the physician.

(jj) Knowingly making a false or misleading statement on a form required by the board or in a written correspondence, including attachments, with the board.

Amended by Laws 1987, Ch. 135, § 1; Laws 1988, Ch. 190, § 1.

[1] Section 20-1341 et seq., and
[2] Section 20-1051 et seq.

Historical Note

The 1988 amendment, in par. "Accreditation Council for Gradu ucation" for "council on medical hospitals of the American medic inserted par. 11 defining "Special ing examination"; in the definitio sional conduct" in subd. (b) del exempting from the subdivision change of information with licensi nary boards; rewrote subd. (*l*) "Gross malpractice, repeated mal malpractice resulting in the death deleted a subdivision relating to g ing rebates; inserted subd. (u) re and fee-splitting; in subd. (x) ad ence to § 36-2302; in subd. (aa) license renewal"; inserted subd. examination of records; and ad relating to false or misleading sta

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Notes of Decisions

32. Unprofessional conduct, gen

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§ 32-1402. Board of medical al; compensation; imm

A. This chapter shall be ad twelve members, two of whom professional nurse who is a me be actively practicing medicine except that no more than five Except for the licensed profes board of nursing, members of ments of members who are governor from a list submitted two names for each vacancy to association, inc., or any of the lists as he may deem expedien case of the vacancy of a profes be later than ninety days after as provided in this section.

B. Each doctor of medicine shall have been a resident of thi a licensed physician or the pract the five years prior to appointm

C. Except for the licensed three years commencing on July office of a member of the terminating on July 1 of the fift for no more than one additiona appointed to fill a vacancy occa the unexpired portion of such

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onstitutes a misdemeanor as to any and all
participating in any such rebate, refund,
d discount or consideration, whether or not
unishable by imprisonment in the county jail
wo thousand five hundred dollars ($2,500), or

Review Commentaries
dvertising and the California medical professional.
e Eric Dizenfeld (1979) 2 Whittier L.Rev. 61.

or as to any and all persons, whether or not
unishable by imprisonment in the county jail
vo thousand five hundred dollars ($2,500), or

Review Commentaries
lvertising and the California medical professional.
e Eric Dizenfeld (1979) 2 Whittier L.Rev. 61.

nd medical licensees

1 Section 2000) of this division may have any
form in or with any person licensed under
sion to whom patients, clients or customers

customers to certain laboratories; excep-

ection 1600) of this division or licensed under
1 or licensed under any initiative act referred
atients, clients, or customers to any clinical
licensee has any membership, proprietary
sharing arrangement, unless the licensee at
h interest to the patient, client, or customer.
ient may choose any clinical laboratory for
performed.

bers of a medical group which contracts to
e prepayment plan registered under the
(commencing with Section 1340) of Division

laboratory which is owned and operated by
cing with Section 1250) of Division 2 of the

ation specimens for proficiency testing or
al laboratory to another clinical laboratory,

es changes or additions by amendment

either licensed or exempt under this chapter, providing the report indicates clearly the laboratory performing the test.

"Proprietary interest" does not include ownership of a building where space is leased to a clinical laboratory at the prevailing rate under a straight lease arrangement.

A violation of this section is a public offense and is punishable upon a first conviction by imprisonment in the county jail for not more than one year, or by imprisonment in the state prison, or by a fine not exceeding ten thousand dollars ($10,000), or by both such imprisonment and fine. A second or subsequent conviction shall be punishable by imprisonment in the state prison.

(Added by Stats.1975, c. 303, p. 751, § 2. Amended by Stats.1978, c. 1161, p. 3592, § 17; Stats.1981, c. 610, p. 2348, § 2.)

Historical Note

1978 Amendment. Substituted, in the second paragraph "Knox-Keene Health Care Service Act of 1975, Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code" for "Knox-Mills Health Plan Act."

1981 Amendment. Substituted in the second sentence of the first paragraph "The written disclosure" for "Such written disclosure" and added the sixth paragraph.

Library References

Physicians and Surgeons ⇐10.
C.J.S. Physicians and Surgeons §§ 31 to 35.

§ 654.2. Prohibited charges, billings, solicitations, or referrals; written disclosure of beneficial interests to patients or third-party payers; definitions; application of section

(a) It is unlawful for any person licensed under this division or under any initiative act referred to in this division to charge, bill, or otherwise solicit payment from a patient on behalf of, or refer a patient to, an organization in which the licensee, or the licensee's immediate family, has a significant beneficial interest, unless the licensee first discloses in writing to the patient, that there is such an interest and advises the patient that the patient may choose any organization for the purpose of obtaining the services ordered or requested by the licensee.

(b) The disclosure requirements of subdivision (a) may be met by posting a conspicuous sign in an area which is likely to be seen by all patients who use the facility or by providing those patients with a written disclosure statement. Where referrals, billings, or other solicitations are between licensees who contract with multispecialty clinics pursuant to subdivision (*l*) of Section 1206 of the Health and Safety Code or who conduct their practice as members of the same professional corporation or partnership, and the services are rendered on the same physical premises, or under the same professional corporation or partnership name, the requirements of subdivision (a) may be met by posting a conspicuous disclosure statement at a single location which is a common area or registration area or by providing those patients with a written disclosure statement.

(c) On and after July 1, 1987, persons licensed under this division or under any initiative act referred to in this division shall disclose in writing to any third-party payer for the patient, when requested by the payer, organizations in which the licensee, or any member of the licensee's immediate family, has a significant beneficial interest and to which patients are referred. The third-party payer shall not request this information from the provider more than once a year.

Nothing in this section shall be construed to serve as the sole basis for the denial or delay of payment of claims by third party payers.

(d) For the purposes of this section, the following terms have the following meanings:

(1) "Immediate family" includes the spouse and children of the licensee, the parents of the licensee and licensee's spouse, and the spouses of the children of the licensee.

(2) "Significant beneficial interest" means any financial interest that is equal to or greater than the lesser of the following:

(A) Five percent of the whole.

(B) Five thousand dollars ($5,000).

(3) A third-party payer includes any health care service plan, self-insured employee welfare benefit plan, disability insurer, nonprofit hospital service plan, or private group or indemnification insurance program.

A third party payer does not include a prepaid capitated plan licensed under the Knox-Keene Health Care Service Plan Act of 1975 or Chapter 11a (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code.

Asterisks * * * indicate deletions by amendment

(e) This section shall not apply to a "significant beneficial interest" which is limited to ownership of a building where the space is leased to the organization at the prevailing rate under a straight lease agreement or to any interest held in publicly traded stocks.

(f)(1) This section does not prohibit the acceptance of evaluation specimens for proficiency testing or referral of specimens or assignment from one clinical laboratory to another clinical laboratory, either licensed or exempt under this chapter, if the report indicates clearly the name of the laboratory performing the test.

(2) This section shall not apply to relationships governed by other provisions of this article nor is this section to be construed as permitting relationships or interests that are prohibited by existing law on the effective date of this section.

(3) The disclosure requirements of this section shall not be required to be given to any patient, customer, or his or her representative, if the licensee, organization, or entity is providing or arranging for health care services pursuant to a prepaid capitated contract with the State Department of Health Services.

(Added by Stats.1984, c. 639, § 1. Amended by Stats.1985, c. 1542, § 1; Stats.1986, c. 881, § 1.)

Historical Note

1986 Legislation

Section 2 of Stats.1986, c. 881, provides:

"In enacting this act, the Legislature intends to make available to third party payers essential data concerning provider investment and financial interest in the facilities or health care businesses to which providers refer their patients for services, and not to create undue administrative burdens on those providers."

Library References

Physicians and Surgeons ⇐10.
C.J.S. Physicians and Surgeons §§ 31 to 35.

Notes of Decisions

Disclosure 2

Organization in which interested 1

1. Organization in which interested

Under West's Ann.Cal.Bus. & Prof.Code § 654.2, prohibiting health care practitioner from referring patient to organization in which practitioner has significant beneficial interest, term "organization" includes any entity that provides services or supplies for practitioner-patient relationship and term "substantial beneficial interest" includes indirect interests such as stock ownership and interests in parent companies which wholly own such organization. 68 Ops.Atty. Gen. 140, 6-25-85.

2. Disclosure

Disclosure required by West's Ann.Cal.Bus. & Prof.Code § 654.2, which prohibits health care practitioner from referring patient to organization in which practitioner has significant beneficial interest absent disclosure of that interest may take any form that is reasonably calculated to apprise patient of practitioner's interest in organization to which referral is made. 68 Ops.Atty.Gen. 140, 6-25-85.

§ 655. Prohibited arrangements between optometrists and registered dispensing opticians or suppliers of optometric appliances or devices

(a) No person licensed under Chapter 7 (commencing with Section 3000) of this division may have any membership, proprietary interest, coownership, landlord-tenant relationship, or any profit-sharing arrangement in any form, directly or indirectly, * * * with any person licensed under Chapter 5.5 (commencing with Section 2550) of this division * * *.

* * * (b) No person licensed under Chapter 5.5 (commencing with Section 2550) of this division may have any membership, proprietary interest, coownership, landlord-tenant relationship, or any profit sharing arrangement in any form directly or indirectly with any person licensed under Chapter 7 (commencing with Section 3000) of this division * * *.

* * * (c) No person licensed under Chapter 7 (commencing with Section 3000) of this division may have any membership, proprietary interest, coownership, landlord-tenant relationship, or any profit-sharing arrangement in any form, directly or indirectly, either by stock ownership, interlocking directors, trusteeship, mortgage, trust deed, or otherwise with any person who is engaged in the manufacture, sale, or distribution to physicians and surgeons, optometrists, or dispensing opticians of lenses, frames, optical supplies, optometric appliances or devices or kindred products.

Any violation of this section constitutes a misdemeanor as to such person licensed under Chapter 7 (commencing with Section 3000) of this division and as to any and all persons, whether or not so licensed under this division, who participate with such licensed person in a violation of any provision of this section.

(Amended by Stats.1979, c. 975, p. 3339, § 1, operative Jan. 1, 1983.)

Historical Note

1979 Amendment. Rewrote the former first two graphs to form subds. (a) to (c).

Section 3 of Stats.1979, c. 975, provided:

"This act shall become operative January 1, 1983."

Law Review Commentaries

Room with a view: The validity of percentage le California optometric tenants. Mark J. Phillips, 6 N U.L.J. Aerospace, Business and Taxation 31 (1985).

Notes of Decisions

1. In general

Franchises offered to optometrists by manufactu ophthalmic products were violative of this sectio §§ 2543, 3041, 3042 prohibiting practices of dis opticians, optometrists, and optical suppliers, in substantial control exercised under franchise agre

§ 655.1. Repealed by Stats.1982, c. 1594,

Historical Note

The repealed section, added by Stats.1982, c. 1 6299, § 1, providing for a study to determine the im

§ 655.2. Employment of hearing aid dis

No physician and surgeon or medical c Section 2000), nor any audiologist who is individual licensed pursuant to Chapter 7.5 or selling hearing aids.

This section shall not apply to any physi with or is affiliated with a comprehensive g the Kaiser-Permanente Health Care Service Pla Division 2 of the Health and Safety Code.

(Added by Stats.1979, c. 970, p. 3323, § 1.)

Library References

Physicians and Surgeons ⇐6(1).
C.J.S. Physicians and Surgeons §§ 10, 23.

§ 655.5. Charge, bill or solicitation of penalty

It is unlawful for any person licensed un this division or for any clinical laboratory patient, client or customer for any clinical l clinical laboratory or under his or her or its is apprised at the first time of such charge, of the clinical laboratory performing the solicitation of payment shall separately se laboratory concerned and shall clearly show account, bill, or charge.

This section shall not apply to any perso with a health care service plan licensed pur such services are to be provided to membe charge or liability on account thereof.

A violation of this section is a public imprisonment in the county jail for not more by a fine not exceeding ten thousand dolla second or subsequent conviction is punisha

(Amended by Stats.1978, c. 1161, p. 3592, §

ARTICLE 6.

General Standards of Practice.

§ 54.1-2962. Division of fees between physicians and surgeons prohibited. — No surgeon or physician shall directly or indirectly share any fee charged for a surgical operation or medical services with a physician who brings, sends or recommends a patient to such surgeon for operation, or such physician for such medical services; and no physician who brings, sends, or recommends any patient to a surgeon for a surgical operation or medical services shall accept from such surgeon or physician any portion of a fee charged for such operation or medical services. This chapter shall not be construed as prohibiting the members of any regularly organized partnership of such surgeons or physicians from making any division of their total fees among themselves as they may determine or a group of duly licensed practitioners of any branch or branches of the healing arts from using their joint fees to defray their joint operating costs. Any person violating the provisions of this section shall be guilty of a Class 1 misdemeanor. (Code 1950, § 54-278; 1956, c. 389; 1988, c. 765.)

Cross reference. — As to punishment for Class 1 misdemeanors, see § 18.2-11.

§ 54.1-2963. Selling vitamins or food supplements in connection with a practice of the healing arts. — The Board shall have authority to promulgate regulations regulating the sale of vitamins or food supplements by any practitioner of the healing arts from the office in which he practices. (1984, c. 325, § 54-278.2; 1988, c. 765.)

§ 54.1-2964. Disclosure of interest in referral facilities. — A. Any practitioner of the healing arts shall, prior to referral of a patient to any facility or entity engaged in the provision of health-related services, appliances or devices, including but not limited to physical therapy, hearing testing, or sale or fitting of hearing aids or eyeglasses provide the patient with a notice in bold print that discloses any known material financial interest of or ownership by the practitioner in such facility or entity and states that the services, appliances or devices may be available from other suppliers in the community. In making any such referral, the practitioner of the healing arts may render such recommendations as he considers appropriate, but shall advise the patient of his freedom of choice in the selection of such facility or entity. This section shall not be construed to permit any of the practices prohibited in § 54.1-2914.

B. The Attorney General, a Commonwealth's attorney, the attorney for a city, county or town, or any aggrieved patient may cause an action to be brought in the appropriate circuit court in the name of the Commonwealth, of the county, city or town, or of any aggrieved patient, to enjoin any violation of this section. The circuit court having jurisdiction may enjoin such violations, notwithstanding the existence of an adequate remedy at law. When an injunction is issued, the circuit court may impose a civil fine to be paid to the Literary Fund not to exceed $1,000. In any action under this section, it shall not be necessary that damages be proven. (1986, c. 348, § 54-278.3; 1988, cc. 765, 874.)

Cross reference. — As to punishment for Class 3 misdemeanors, see § 18.2-11.

Editor's note. — Pursuant to Acts 1988, c. 765, cl. 5, effect has been given in this section, as set out above, to Acts 1988, c. 874, which amended former § 54-278.3, which was comparable to this section.

Acts 1988, c. 874, designated the existing provisions as subsection A, in the first sentence of subsection A substituted "provide the patient with a notice in bold print that discloses any known material" for "disclose to the patient any" and added the language beginning "and states that the services," deleted the last sentence of subsection A, which read: "Any person violating the provisions of this section shall be guilty of a Class 3 misdemeanor," and added subsection B.

§ 54.1-2965. Regulations governing practice of acupuncture. — The Board shall promulgate regulations governing the practice of acupuncture. In the formulation of such regulations, the Board shall recognize that the practice of this modality requires the exercise of professional judgment, and may give consideration to such timely information and suggestions as may be provided by the national and state associations representing branches of the healing arts, by the National Institutes of Health and by the medical institutions in this Commonwealth at which research is being conducted with respect to acupuncture. This section shall not have the effect of restricting the practice of acupuncture to medical institutions or hospitals at which research is being performed with respect to acupuncture. (1975, c. 512, § 54-274.1; 1988, c. 765.)

§ 54.1-2966. Physicians reporting disabilities to aircraft pilots licensing authorities exempt from liability; testifying in certain proceedings. — A. Any physician who, in good faith, reports the existence, or probable existence, of a mental or physical disability or infirmity in any person licensed or certificated to operate any type of aircraft, or any applicant for a license or certificate to operate any type of aircraft, to a governmental agency which is responsible for issuing, renewing, revoking or suspending such licenses or certificates, or which is responsible for air safety, which the physician believes will or reasonably could affect such person's ability to safely operate the aircraft he is licensed or certificated, or is seeking to be licensed or certificated, to operate shall not be liable for any civil damages resulting from such reporting, regardless of whether such person is, or has been, a patient of such physician, except when such reporting was done with malice.

B. Notwithstanding any provision of § 8.01-399, any physician may testify in any administrative hearing or other proceeding regarding the issuance, renewal, revocation or suspension of any license or certificate to pilot an aircraft of any person, regardless of whether such person is, or has been, a patient of such physician, giving evidence of the existence or probable existence, of a mental or physical disability or infirmity. (1978, c. 561, § 54-276.9:1; 1988, c. 765.)

§ 54.1-2966.1. Physicians reporting disabilities of drivers. — Any physician who reports to the Department of Motor Vehicles the existence, or probable existence, of a mental or physical disability or infirmity of any person licensed to operate a motor vehicle which the physician believes affects such person's ability to operate a motor vehicle safely shall not be deemed to have violated the physician-patient privilege unless he has acted in bad faith or with malicious intent. (1988, c. 798, § 54-276.9:2.)

Editor's note. — This section was enacted as § 54-276.9:2 by Acts 1988, c. 798. Pursuant to Acts 1988, c. 765, cl. 5, this section has been incorporated into Title 54.1 as § 54.1-2966.1.

CHAPTER 4515
ETHICAL PRACTICES BOARD
CONFLICTS OF INTEREST

4515.0100 DEFINITIONS.
4515.0200 PURPOSE.
4515.0300 APPLICABILITY OF THE CONFLICTS OF INTEREST PROVISIONS.
4515.0400 NOTICE OF CONFLICT OF INTEREST.
4515.0500 REMOVAL FROM CONFLICT OF INTEREST.
4515.0600 OBTAINING AND FILING FORMS.
4515.0700 CHANGES AND CORRECTIONS.
4515.0800 FILING OF FALSE STATEMENTS.

4515.0100 DEFINITIONS.

Subpart 1. Applicability. When they are used in this chapter, the terms defined in this part have the meanings given them.

Subp. 2. Address. "Address" means, for an individual, the individual's home mailing address or, for an association, the place where the association conducts its business, including the street and number, the post office box or rural route, if appropriate, the room number, and the city, state, and zip code. An individual may provide a business address rather than a home mailing address.

Subp. 3. [Repealed, 10 SR 1266]

Subp. 4. Calendar year. "Calendar year" means the period from January 1 through December 31 inclusive in any given year.

Subp. 5. Financial interest. "Financial interest" means any asset owned or controlled by an individual or business which has the potential to produce a monetary return.

Subp. 6. Public official. "Public official" has the meaning given in Minnesota Statutes, section 10A.01, subdivision 18.

Subp. 7. Superior for purposes of notification of a potential conflict of interest. "Superior for purposes of notification of a potential conflict of interest" means:

A. if the public official is a member of a board or commission having rulemaking authority, or a member of a metropolitan agency, the chairman of such board, commission, or agency, or, if the potential conflict of interest involves the chairman, the superior shall be deemed to be the appointing authority for that office;

B. if the public official is an employee of a state agency, the department head of that agency or, if the potential conflict of interest involves the department head, the superior shall be deemed to be the appointing authority for that office;

C. if the public official is a member of the legislature, the presiding officer of the body in which the public official serves, or if the potential conflict of interest involves the presiding officer, the acting presiding officer; and

D. if the public official is a member of the staff of the legislature, the chief clerk of the house or the secretary of the senate shall be deemed to be the superior, or, if the potential conflict should involve the chief clerk of the house or the secretary of the senate, the presiding officer of the legislative body which the public official serves.

Statutory Authority: *MS s 10A.02 subd 13*

History: *10 SR 1266; 11 SR 1611*

4515.0200 PURPOSE.

The purpose of parts 4515.0100 to 4515.0800 is to implement the conflicts of interest provisions of Minnesota Statutes, chapter 10A.

Statutory Authority: *MS s 10A.02 subd 13*

4515.0300 APPLICABILITY OF THE CONFLICTS OF INTEREST PROVISIONS.

Any public official who, in the discharge of official duties, would be required to take action or make a decision which would substantially affect the official's financial interests, or those of a business with which he is associated, as that term is defined in Minnesota Statutes, section 10A.01, subdivision 4, must file a potential conflict of interest notice, unless the effect on the official is no greater than on other members of the official's business classification, profession, or occupation.

Statutory Authority: *MS s 10A.02 subd 13*

History: *10 SR 1266*

4515.0400 NOTICE OF CONFLICT OF INTEREST.

Subpart 1. **Normal procedure.** Whenever a public official is required to file a conflict of interest statement he shall prepare a potential conflict of interest notice describing the matter requiring action or decision and the nature of his potential conflict of interest. The public official shall deliver copies of the potential conflict of interest notice to the board and to his immediate superior.

Subp. 2. **Insufficient time available.** If a potential conflict of interest presents itself and there is insufficient time to comply with the provisions of subpart 1, the public official shall orally inform his immediate superior of the potential conflict. He shall file a potential conflict of interest notice with the board within one week after the potential conflict presents itself. This notice shall indicate the reason for noncompliance with the provisions of subpart 1.

Statutory Authority: *MS s 10A.02 subd 13*

4515.0500 REMOVAL FROM CONFLICT OF INTEREST.

Subpart 1. **Nonlegislator.** If the public official is not a legislator, subsequent to the filing of a potential conflict of interest notice, or subsequent to oral notice of a potential conflict of interest by a public official, his immediate superior shall assign the matter, if possible, to another employee who does not have a potential conflict of interest. If the public official who has a potential conflict of interest does not have an immediate superior except for notification purposes, the public official shall do one of the following. Where the public official having the potential conflict of interest is not required by law to determine the matter, he shall either assign the matter to a subordinate for disposition or request the appointing authority to designate another to determine the matter. Where the public official having the potential conflict of interest is required by law to determine the matter, he shall so notify by certified mail all affected parties known to him by providing these parties with copies of the potential conflict of interest notice. A public official having the potential conflict of interest shall not chair a meeting, participate in any vote, or offer any motion on the matter giving rise to his potential conflict of interest.

Subp. 2. **Legislator.** If the public official is a legislator, the house of which he is a member may, at his request, excuse him from taking part in the action or decision in question.

Statutory Authority: *MS s 10A.02 subd 13*

4515.0600 OBTAINING AND FILING FORMS.

All potential conflict of interest notices shall be on the forms made available by the board and must be filed with the board.

Statutory Authority: *MS s 10A.02 subd 13*

4515.0700 CHANGES AND CORRECTIONS.

Any material changes in information contained in a potential conflict of

MMA
MINNESOTA MEDICAL ASSOCIATION
612/378-1875

L. Ashley Whitesell, M.D.
PRESIDENT
Lawrence M. Poston, M.D.
PRESIDENT-ELECT
Robert D. Christensen, M.D.
CHAIRMAN OF THE BOARD
Steven D. Carter
CHIEF EXECUTIVE OFFICER

May 3, 1988

Melvin Sigel, M.D.
President
Minnesota Board of Medical Examiners
2700 University Avenue West, Suite 109
St. Paul, MN 55114

Dear Dr. Sigel:

With the recent passage of The Board of Medical Examiners' bill which amends the Medical Practice Act, the Minnesota Medical Association strongly feels that there is need for administrative rulemaking to clarify ambiguous terms in the revision of the fee-splitting prohibition. As I am sure you are aware from previous communications with the MMA, there is a great deal of concern over the precise meaning and application of several terms in the revised fee-splitting law, e.g. profit interest, financial interest, etc. As we've already indicated to various members of the Board, we believe it would be unfair to enforce ambiguous provisions without further clarification of key terms.

We understand that the first portion of the revised fee-splitting prohibition is modeled after the federal laws prohibiting fraud and abuse in the Medicare and Medicaid systems. We anticipate that Minnesota BME interpretations of this new law would parallel the federal government's interpretations of the federal law.

The division of fees in proportion to services provided and responsibility assumed, we anticipate, may be judged or reviewed based upon a rule of reason standard as you and other representatives of the Board have previously described.

With regard to the definition of significant financial interest, we believe that a firm definition needs to be arrived at for this term. The most appropriate method may be to set a specific percentage of direct ownership.

The profit interest in the dispensing of drugs or devices is also in need of specific clarification. We are hopeful that the definition of profit interest promulgated by rule would exclude some amount necessary to cover stocking and overhead charges which may be added to the price of a drug or device dispensed by a physician.

Also in need of careful consideration and explication through rulemaking are the disclosure requirements which will be expected by the Board. Compliance through posting of a notice of disclosure in an area commonly used by and accessible to patients of the physician has been discussed. The key element of any rule promulgated under this provision should be the effective communication of the information to the patient without posing an unreasonable burden on physicians.

We look forward to working with you in the speedy promulgation of these rules and will extend whatever assistance you may require.

Sincerely,

Robert D. Christensen, MD

Robert D. Christensen, M.D.
Chair, MMA Board of Trustees

RDC/RE:crp

cc: H. Leonard Boche
Executive Director
Board of Medical Examiners

Look forward to seeing you at the Annual meeting
- Bob

ST. PAUL UROLOGY, P.A.
658 DOCTORS PROFESSIONAL BUILDING
280 NORTH SMITH AVENUE
ST. PAUL, MINNESOTA 55102

ROBERT W. GEIST, M.D.
STANLEY J. ANTOLAK, JR., M.D.
MICHAEL L. PERGAMENT, M.D.
EILEEN A. TOOLIN, M.D.

PRACTICE LIMITED TO UROLOGY
612/227-9518

May 9, 1988

Mr. Leonard Boche
Executive Director, Board of Medical Examiners
2700 University Avenue West
Suite 106
St. Paul, Minnesota 55114-1080

Dear Mr. Boche:

I spoke with Ms. Kathy Welte, our Executive Secretary of the Ramsey County Medical Society the other day and was pleased by your reception of the concerns physicians have about fee-splitting following the recent legislative session. The new fee-splitting ammendments contain ambiguities that will need clarification with rule making.

I have enclosed a contract which was recently given to one of our St. Paul surgeons (see attachment A). It involves a contract specifically intended to involve an independant contractor in a.) splitting fees for procedures not done on a clinic owned site and b.) splitting fees for for on-site clinic services which may be in excess of any ordinary clinic overhead.

a.) The first element of the contract appears to be a clear violation of Federal statutes (see attachment B). I would recommend that the Board of Medical Examiners consider using the concept and/or language of Federal law when regulating services delivered off a clinic site by an independant contractor.

b.) The second element of the contract appears to split fees in excess of ordinary clinic overhead. This might be a search for "acceptable limits" meant by "in proportion to the services provided ..." in Sec. 147.091, Subdiv. 1 (p)(2). A proportional division of fees does not seem to stand out in the language of the enclosed contract.

The new law does not spell out in detail how this proportionality is to be determined. One supposes that the proper maximum for division of fees would best be determined by the ordinary clinic overhead with freedom to choose other methods which might decrease

patient costs such as division based on hourly, daily, weekly, or monthly rentals comparable to facilities in the same area. It was with these fair rental examples that I had suggested language for paragraph (p)(2) which I have enclosed (see attachment C). This language was eventually rejected by the MMA Board of Trustees, not considered by the BME as far as I know, and not considered by the Legislature. I hope the Board would now consider this language carefully when writing regulations as a fair rental principle would get rid of ambiguities in the law and would prevent unanticipated improper actions in the future.

I know the Board shares the concerns of many physicians that improper division of fees, i.e., "fee-splitting", for referral of patients is a great danger to the public. I won't go into the incentive fee-splitting creates to order more services, to actually raise fees to cover the cost of the kickback, and to the creation of monopolies between contractors to freeze out competition. A fundamental problem for patients is that they are almost invariably sold for servicing to another provider with the biggest kickback rather than being sent to the best consultant, hospital, laboratory, or pharmacist. Please let me know if I can be of any help in your deliberations. I know the medical community will welcome your open reception of commentary prior to carving the regulations in stone.

Sincerely yours,

Robert W. Geist, M.D.

RWG/ntn

cc: Ms. Kathy Welte
Ramsey County Medical Society

Mr. Thomas Hoban
Hennipen County Medical Society

Mr. Steven Carter
Minnesota Medical Association

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This Agreement of Limited Partnership, made and entered into as of this 6th day of April, 1988, by and among Quantum Corporation, a Tennessee professional S corporation, with its principal place of business located at 311 22nd Avenue North, Nashville, Tennessee, 37203, as the General Partner (the "General Partner"), and Ted MacDonald, whose mailing address is 311 22nd Avenue North, Nashville, Tennessee, 37203, as the Original Limited Partner (the "Original Limited Partner") and the other persons who may become Limited Partners under the terms of this Agreement (each a "Limited Partner" and collectively the "Limited Partners"). The parties hereto agree as follows:

I. DEFINITIONS

When used in this Agreement, the following terms shall have the meanings set forth below:

1.1 "Act" means the Delaware Revised Uniform Limited Partnership Act, Sections 17-101 et seq. of the Delaware Code Annotated, as amended from time to time.

1.2 "Agreement" means this Agreement of Limited Partnership, as amended from time to time.

1.3 "Available Cash Flow" means all cash funds of the Partnership on hand at the end of each calendar quarter, less (i) provisions for payment of all outstanding and unpaid current cash obligations of the Partnership at the end of such quarter (including those which are in dispute), and (ii) provision for adequate reserves, as determined by the General Partner in its sole discretion.

1.4 "Capital Contribution" in respect of any Partner or transferee of such Partner's Interest(s) means the amount of all cash contributed by such Partner to the capital of the Partnership.

1.5 "General Partner" means the party designated as the "General Partner" in the first paragraph of this Agreement and any substitute therefor elected as provided in Section 11.5 of this Agreement.

1.6 "Gross Collected Revenues" shall mean total revenues of the Partnership from all sources, excluding interest earned and refunds to patients, including but not limited to fees for services purchased by customers, patients, etc., and revenue from transaction fees generated by relationships with third-party fiscal intermediaries.

1.7 "Interest" means an Interest in the initial capital of the Partnership of an amount equal to the Capital Contribution per Interest, as determined by the General Partner. The authorized number of Interests of the Partnership is 297.

1.8 "Limited Partners" shall mean the persons who are, from time to time, admitted to the Partnership as Limited Partners, and whose names, mailing addresses, taxpayer identification numbers, and number of Interests owned by each, appear as Annex A to this Agreement, as maintained in the files of the General Partner and as revised from time to time. Each Limited Partner must be a physician, health care professional, or an affiliate thereof. Persons shall become Limited Partners effective as of the date that they are deemed to become Limited Partners pursuant to Section 8.6 of this Agreement.

1.9 **"Limited Partnership Percentage"** in respect of any Limited Partner means that fraction, expressed as a percentage, having as its denominator the total number of Interests owned by all Limited Partners.

1.10 **"Original Commitment"** in respect of any Limited Partner, other than the Original Limited Partner, means the product obtained by multiplying the number of Interests owned by such Limited Partner by an amount of dollars determined by the General Partners to be the per Interest Capital Contribution.

1.11 **"Partners"** means collectively the General Partner and the Limited Partners.

1.12 **"Partnership"** means the Limited Partnership formed pursuant to this Agreement.

1.13 "Partnership Return" means the United States Partnership Information Return of Income of the Partnership.

II. ORGANIZATION

2.1 Formation. The parties hereby enter into this Agreement to set forth the business agreement pertaining to the Partnership, which was formed pursuant to Section 17-206 of the Act by the filing for record a Certificate of Limited Partnership on the _____ day of _____, 1988 (the "Certificate").

2.2 Name. The name of the Partnership is Nashville Imaging Center, L.P. The business of the Partnership may be conducted under any name chosen by the General Partner and the General Partner may in its sole discretion from time to time change the name of the Partnership.

III. PRINCIPAL PLACE OF BUSINESS; REGISTERED OFFICE, AND AGENT FOR SERVICE OF PROCESS

3.1 The principal place of business of the Partnership shall be located initially in Nashville, Tennessee and may be located at 311 22nd Avenue North, or at such other place as the General Partner may from time to time designate by notice to the Limited Partners. The Partnership's registered office and registered agent in Delaware shall be: The Corporation Trust Company, Corporation Trust Center, 1209 Orange Street, Wilmington, Delaware 19801.

IV. BUSINESS

4.1 The business to be conducted by the Partnership shall be to provide practice management, financial, and other related services to physicians and health care professionals and to carry on any and all activities necessary, proper, convenient, or advisable in connection therewith. In the discretion of the General Partner, the Partnership may also engage in other medical related business, such as development of an Outpatient Diagnostic Imaging Center.

V. TERM

5.1 The Partnership shall exist for 20 years from the date on which the Certificate of Limited Partnership was filed with the office of the Secretary of State of the State of Delaware unless terminated sooner pursuant to Section 12 of this Agreement.

VI. CAPITAL CONTRIBUTION AND STATUS

6.1 Capital Contribution of the General Partner. The General Partner shall make an aggregate capital contribution to the Partnership equal to 1% of the aggregate Capital Contributions made to the Partnership, payable by $3,000 in cash upon becoming the General Partner and upon admission of Limited Partners (other than the Original Limited Partner) to the Partnership.

6.2 Contribution of the Original Limited Partner to Partnership Capital. The Original Limited Partner shall contribute $100 in cash to the capital of the Partnership upon the formation of the Partnership and shall be a Limited Partner solely to facilitate the formation of the Partnership. Such contribution shall be returned to him in cash on the day of the admission of any other person or persons as a Limited Partner or Limited Partners, or on May 17, 1988 (or on July 18, 1988, if the offering period is extended by the General Partner, in its sole discretion), whichever first occurs, at which time the Original Limited Partner shall withdraw as the Original Limited Partner. The General Partner and each Limited Partner hereby consent to the withdrawal by the Original Limited Partner of his $100 contribution pursuant to this Section 6.2, and hereby waive and release the Original Limited Partner from any right, claim, or action that they or any of them may have against him for such withdrawal.

6.3 Capital Contribution of the Limited Partners. Each Limited Partner, other than the Original Limited Partner, shall make a contribution to the capital of the Partnership equal to his Original Commitment. Such contribution shall be $1,000 in cash.

6.4 Limited Liability. A Limited Partner shall not be bound by, or personally liable for, the expenses, liabilities, or obligations of the Partnership, except as provided in the Act.

6.5 Role of Limited Partners. Except as otherwise provided in this Agreement, a Limited Partner shall take no part in or interfere in any manner with the conduct or control of the business of the Partnership and shall have no right or authority to act for or bind the Partnership.

6.6 Withdrawal of Capital Contribution. Except as provided in Section 6.2 hereof, no Limited Partner shall have the right to withdraw or reduce his Capital Contribution without the consent of the General Partner. No Limited Partner shall have the right to demand or receive property other than cash in return for his Capital Contribution, and, except as provided in Section 6.2, no Limited Partner shall have priority over any other Limited Partner, either as to the return of Capital Contributions or as to profits, losses, or distributions.

VII. EXPENSES OF THE PARTNERSHIP

7.1 Reimbursement of Expenses Incurred by General Partner. The General Partner may charge the Partnership for all direct and indirect expenses incurred by it in connection with the Partnership's business including legal, accounting, record keeping and data processing services. The General Partner may also charge the Partnership with allocable portions of direct expenses incurred in connection with both Partnership and other activities, such allocation to be determined on any basis selected by the General Partner consistent with good accounting practice.

7.2 Development and Advanced Marketing Expenses. The Partnership will reimburse the General Partner for any expenses incurred by it in connection with the organization of the Partnership ("Development Costs"). Such Development Costs will not exceed $150,000. The General Partner will defer reimbursement until the Limited Partners receive an aggregate $150,000 in cash distributions. The General Partner will then receive 50% of all cash distributions until it has been reimbursed for the Development Costs. The General Partner will also advance the Partnership all marketing costs until the Limited Partners receive aggregate cash distributions totaling $150,000. After this, the Partnership will be responsible for paying the marketing costs as they are incurred. After the Limited Partners receive cash distributions totaling $300,000, the General Partner will receive 50% of all cash distributions until the advanced marketing costs are reimbursed.

7.3 Fees Receivable by the General Partner and Affiliates. The General Partner and its affiliates will receive on the terms and conditions hereinafter set forth certain fees and compensation, which shall be in addition to the Interest of the General Partner in the taxable income and loss and Available Cash Flow of the Partnership. Each Limited Partner, upon his execution of this Agreement, hereby approves, consents to, and ratifies all of the arrangements pursuant to which the fees described below are to be paid.

7.3.1 Partnership Management Fee. The General Partner and its affiliates will receive no management fee for services in managing the day-to-day operations of the Partnership.

VIII. ALLOCATION OF INCOME AND LOSS; CASH DISTRIBUTIONS

8.1 Capital Accounts. Each Partner shall have a capital account to which such Partner's Capital Contribution less his share of any syndication expenses shall be credited. Each Partner's share of Partnership income or loss shall be charged or credited at least annually to such Partner's capital account. No interest shall be payable on the Capital Accounts of the Partners. The Capital Accounts shall be maintained and adjusted in accordance with the principals set forth in Treasury Regulation Section 1.704-1(b).

8.2 Allocation of Profits and Losses and Distributions of Cash. The terms profits and losses, as used shall mean and refer to net profits and net losses for United States Income Tax purposes, including the taking into account of all items separately stated for United States Income Tax purposes on United States Partnership Income Tax returns.

8.2.1 Distributions of cash allocated to the Limited Partners shall be apportioned among the Limited Partners pro rata per Units sold as follows:

(a) When the Limited Partners receive $150,000 in cash distributions, the General Partner will receive 50% of all subsequent cash distributions until the General Partner has been reimbursed the $150,000 they advanced the Partnership for Development Costs;

(b) When the Limited Partners receive $150,000 in cash distributions, the Partnership will pay for all marketing costs as they are incurred. After the Limited Partners receive $300,000 in cash distributions and the Development Costs have been reimbursed to the General Partner, the General Partner will receive 50% of cash distributions until all the advanced marketing costs have been reimbursed;

(c) After (a) and (b) above occur, the net income and losses will be allocated 99% to the Limited Partners and 1% to the General Partner;

(d) Notwithstanding the foregoing, if there is a net decrease in the Partnership's minimum gain, as defined in Treasury Regulation 1.704-1(b)(4)(iv)(c), during any taxable year any Partner or Partners with negative Capital Account balances at the end of such year, shall be allocated income or gain in an amount equal to the sum of such deficits. Such amount shall be allocated among the Partners with negative Capital Account balances in the proportion each Partner's negative Capital Account balance bears to the sum of all such Partners' negative Capital Account balances. For purposes of this Section 8.2.1(i) each Partner's Capital Account shall be increased by any amount such Partner is obligated to restore, or deemed obligated to restore under Treasury Regulation 1.704-1(b)(4)(iv), upon liquidation. The allocations under this Section 8.7(a) shall be interpreted in a manner to conform with Treasury Regulation Section 1.704-1(b)(4)(iv); and

(e) Notwithstanding the foregoing, if a Partner's Capital Account is reduced below the amount he or she is obligated to restore, or deemed obligated to restore under Treasury Regulation 1.704-1(b)(4)(iv), upon liquidation by: (i) the allocation of loss or deduction to him or her under Treas. Reg. 1.751-1(b)(2)(ii) or (iii) distributions to him or her, he or she shall be allocated, as quickly as possible, items of Partnership income and gain equal to the amount by which his Capital Account is so reduced. For purposes of this Section 8.21(d) each Partner's Capital Account shall be reduced for the items described in Treasury Regulation Section 1.704-(b)(ii)(4)(5) and (6). Such allocation shall be interpreted to conform with Treasury Regulation 1.704(b)(2)(ii)(d).

8.2.2 Upon the total or partial liquidation of the Partnership, including the sale or disposition of the Partnership's assets or the refinancing thereof in a manner generating taxable income, the following allocation will apply:

(a) Income and gain, if any, in an amount up to the sum of the negative Capital Account balances of all Partners with such balances shall be allocated to such Partners in proportion to their respective negative Capital Account balances after allocations are made with respect to the negative Capital Accounts to the extent resulting from allocations of loss or deduction attributable to non-recourse debt secured by Partnership property in accordance with Proposed Treasury Regulation Section 1.701-1; and

(b) Net income or net loss, if any, after reducing income for the allocation under subsection 8.2.2(a) above and for all Partnership expenses and losses, shall be allocated 1% to the General Partner and 99% to the Limited Partners.

8.3 Distribution of Available Cash Flow. The General Partner shall distribute 99% of the Available Cash Flow of the Partnership to the Limited Partners and 1% to the General Partner until the Limited Partners recover $150,000 of their original capital contributions; after that the distribution will be 50% to the Limited Partners and 50% to the General Partner until the General Partner is reimbursed $150,000 for the advanced Development Costs. The General Partner will advance all marketing costs until the Limited Partners receive $150,000 in cash distributions. After the Limited Partners receive $150,000 in cash distributions, the Partnership will pay the marketing costs as they are incurred. When the Limited Partners receive $300,000 in cash distributions, the General Partner will receive 50% of cash distributions until all the advanced Marketing Costs have been reimbursed. However, in no event shall the proceeds from the sale of all or substantially all of the Partnership's assets be distributed other than in accordance with the ending Capital Account balances of the Partners immediately prior to such distribution. Such distributions may, at the direction of the General Partner, be made in monthly installments within 45 days after the end of such calendar month or at such time or times as the General Partner shall deem practicable.

8.4 Allocations and Distributions to the Limited Partners. For purposes of this Section 8, all allocations and distributions to the Limited Partners shall be made in accordance with their respective Limited Partnership Percentages.

8.5 Consequences of Distributions. Upon the determination to distribute funds in any manner expressly provided in this Section 8, made in good faith, the General Partner shall incur no liability on account of such distribution, even though such distribution may have resulted in the Partnership retaining insufficient funds for the operation of its business which insufficiency resulted in loss to the Partnership or necessitated the borrowing of funds by the Partnership.

8.6 Partner Admission Date; Allocation of Net Income, Net Loss and Distributions in Respect of Interests Transferred. A purchaser of Interests shall become a Limited Partner on the date that both (i) his Capital Contribution, is disbursed by an escrow agent, or other appropriate person or entity designated by the General Partner to receive Capital Contributions from purchasers of Interests, and (ii) the General Partner accepts such purchaser's subscription agreement. If one or more Interests are transferred during any fiscal year of the Partnership, the net income

or net loss attributable to such Interest or Interests for such fiscal year shall be divided and allocated between the transferror and the transferee based on the time each such party was, according to the books and records of the Partnership, the owner of record of the Interest or Interests transferred during the year in which the transfer occurs. If the transfer occurs on or before the last day of the month, the transferror shall be deemed not to be a Partner as of the date the transfer actually occurs, and the transferee shall, for these purposes, be deemed to be a Partner as of the like day. Distributions of Partnership assets in respect of Interests shall be made only to persons who according to the books and records of the Partnership are the owners of such Interests on a date selected by the General Partners. The General Partner and the Partnership shall incur no liability for making distributions in accordance with the provisions of the preceding sentence whether or not the General Partner or the Partnership have knowledge or notice of any transfer of ownership of any Interest or Interests.

8.7 Allocation of Syndication Expenses. Any syndication expense, as outlined in Code Section 709, shall be allocated to and among the Partners in the same manner as taxable income.

IX. RIGHTS, POWERS, AND OBLIGATIONS OF THE GENERAL PARTNER

9.1 Powers. The management and control of the Partnership and its business and affairs shall rest exclusively with the General Partner, who shall have all rights and powers which may be possessed by a general partner pursuant to the Act, and such additional rights and powers as are otherwise conferred by law or are necessary, advisable or convenient to the discharge of its duties under this Agreement. Without limiting the generality of the foregoing, the General Partner may, at the cost, expense, and risk of the Partnership:

9.1.1 Spend the capital and net income including, without limitation, any reserve fund for working capital, repairs, improvements, and capital expenditures, of the Partnership in the exercise of any rights or powers possessed by the General Partner hereunder;

9.1.2 Purchase, lease, construct, equip, hold, and operate the assets of the Partnership, and enter into agreements containing such terms, provisions, and conditions as the General Partner in its discretion shall approve;

9.1.3 Purchase from or through others contracts of liability, casualty, and other insurance which the General Partner deems advisable for the protection of the Partnership or for any purpose convenient or beneficial to the Partnership;

9.1.4 Subject to the provisions of Section 9.4.2 and 9.4.4 of this Agreement, incur indebtedness;

9.1.5 Subject to the provisions of Section 9.4.2(a) of this Agreement sell or otherwise dispose of, upon such terms and conditions as the General Partner may deem advisable, appropriate, or convenient, any of the assets of the Partnership;

9.1.6 Invest in short-term debt obligations (including obligations of federal and state governments and their agencies and certificates of deposit of commercial banks, savings banks, or savings and loan associations) and "money market" mutual funds as are temporarily not required for the purposes of the Partnership's operations;

9.1.7 Delegate all or any of its duties hereunder and, in furtherance of any such delegation, appoint, employ, or contract with any person (including affiliates of the General Partner) for the transaction of the business of the Partnership, which persons may, under the supervision of the General Partner, act as consultants, accountants, attorneys, brokers, escrow agents, leasing agents, or in any other capacity deemed by the General Partner necessary or desirable, and pay appropriate fees to any of such persons.

9.2 Duties. The General Partner shall manage and control the Partnership, its business and affairs to the best of its ability and shall use its best efforts to carry out the business of the Partnership. The General Partner shall devote itself to the business of the Partnership to the extent that it, in its discretion, deems necessary for the efficient carrying on thereof. The General Partner shall act as a fiduciary with respect to the safekeeping and use of the funds and assets of the Partnership.

9.3 The Tax Matters Partner.

(a) Each Partner, by the execution of this Agreement, consents to the appointment of the General Partner, as the tax matters partner and agrees to execute, certify, acknowledge, deliver, swear to, file, and record at the appropriate public offices such documents as may be necessary or appropriate to evidence such consent.

(b) The tax matters partner shall have the following duties, along with any other duties required by the Code, to the extent and in the manner provided by the Code:

(1) Furnish the name, address, profits, Interest, and taxpayer identification number of each Partner to the IRS;

(2) Keep each Partner informed of the administrative and judicial proceedings for the adjustment of any item required to be taken into account by a Partner for income tax purposes;

(3) Within 30 days of receiving a notice of a Partnership audit by the IRS, forward a copy of such notice to the Partners; and

(c) The tax matters partner is hereby authorized, but not required, to:

(1) Enter into any settlement with the IRS with respect to any tax audit or judicial review, in which agreement the tax matters partner may expressly state that such agreement shall bind the other Partners, except that such settlement agreement shall not bind any Partner who (within the time prescribed pursuant to the Code and

regulations thereunder) files a statement with the IRS providing that the tax matters partner shall not have the authority to enter into a settlement agreement on the behalf of such Partner;

(2) If a final administrative adjustment of a Partnership item required to be taken into account by a Partner for tax purposes is mailed to the tax matters partner, seek judicial review of such final adjustment, including the filing of a petition for readjustment with the Tax Court, the District Court of the United States for the district in which the Partnership's principal place of business is located, or the United States Claims Court;

(3) Intervene in any action brought by any other Partner for judicial review of a final adjustment;

(4) File a request for an administrative adjustment with the IRS at any time and, if any part of such request is not allowed by the IRS, file a petition for judicial review with respect to such request;

(5) Enter into an agreement with the IRS to extend the period for assessing any tax which is attributable to any item required to be taken into account by a Partner for tax purposes, or an item affected by such item;

(6) Take any other action on behalf of the Partners or the Partnership in connection with any administrative or judicial tax proceeding to the extent permitted by applicable law or regulations; and

(7) To file a petition as contemplated in Sections 6226(a) and/or 6228 of the Internal Revenue Code.

(d) The Partnership shall indemnify and reimburse the tax matters partner for all expenses, including legal and accounting fees, claims, liabilities, losses, and damages incurred in connection with any administrative or judicial proceeding with respect to the tax liability of the Partners and against any and all loss, liability fees, and expenses, incurred by the tax matters partner in any civil, criminal, or investigative proceedings in which the tax matters partner is involved or threatened to be involved solely by virtue of being tax matters partner, except such loss, liability, cost, or expense arising by virtue of the tax matters partner's gross negligence, fraud, malfeasance, breach of fiduciary duty, or intentional misconduct. The payment of all such expenses shall be made before any distributions are made. Neither the General Partner, or any affiliate, nor any other person shall have any obligation to provide funds for such purpose. The taking of any action and the incurring of any expenses by the tax matters partner in connection with any such proceeding, except to the extent required by law, is a matter in the sole discretion of the tax matters partner and the provisions on limitations of liability of the General Partner and indemnification set forth in this Agreement shall be fully applicable to the tax matters partner in its capacity as such.

9.4 Certain Limitations.

9.4.1 Without obtaining the consent of Limited Partners holding a Limited Partnership Percentage of greater than 50%, the General Partner shall not:

(a) Act in contravention of this Agreement;

(b) Except as provided in Section 12 and Section 9.4.2.(a) of this Agreement, do any act which would make it impossible to carry on the ordinary business of the Partnership;

(c) Confess a judgment against the Partnership;

(d) Possess Partnership property, or assign any rights in specific Partnership property, including any judgment for the benefit of Partnership creditors, for other than a Partnership purpose or;

(e) Admit a person as a General Partner or as a Limited Partner other than as provided in this Agreement.

9.4.2 Without obtaining the consent of Limited Partners holding an aggregate Limited Partnership Percentage greater than 50%, the General Partner shall not:

(a) Sell or transfer all or substantially all of the assets of the Partnership; or

(b) Incur any indebtedness other than indebtedness in the aggregate amount of $300,000 and indebtedness incurred in the ordinary course of business of the Partnership.

9.4.3 In no event shall the General Partner amend this Agreement, except as provided in Section 10.2 and 10.3 and Section 16 hereof without the consent of more than 50% of the Limited Partner Interests.

9.4.4 The General Partner shall not incur any indebtedness pursuant to a non-recourse loan if the creditor shall have or acquire at any time as a result of making the loan, any direct or indirect Interest in the profits, capital, or property of the Partnership other than as a secured creditor.

9.5 Net Worth of the General Partner. The General Partner, and any General Partner substituted therefor thereafter, shall have an maintain at all times during which it (or such substitute) is the General Partner of the Partnership, an aggregate net worth which is sufficient to conduct the business of the Partnership in a prudent manner and to preserve the classification of the Partnership as a "partnership" for federal income tax purposes.

9.6 At any time after two years from the date upon which the Limited Partnership Certificate is recorded, any General Partner may withdraw as a General Partner upon 180 days prior written notice to all

the Partners. Such notice shall indicate the proposed effective date of such withdrawal. Such withdrawal by all the General Partners shall effect a dissolution of the Limited Partnership, except as otherwise provided in this Limited Partnership Agreement. If the business of the Limited Partnership is to be continued: (a) the withdrawing General Partner shall use its best efforts to find a successor who has indicated that it would be willing to serve as General Partner under the terms of this Agreement, and if the successor General Partner is a corporation, whose net worth when considered together with the net worth of the remaining General Partners, if any, meets current United States Internal Revenue Service standards for determining whether the Limited Partnership is taxable as such; (b) a successor General Partner may be admitted as such only with the prior written consent of all the remaining General Partners, if any, and two-thirds of the Limited Partners except that if there is no remaining General Partner, the consent of all Limited Partners must be obtained; and (c) such withdrawal notice shall be deemed an offer by the withdrawing General Partner to sell its Partnership Interest in accordance with this Limited Partnership Agreement.

X. TRANSFER AND SALE OF INTEREST IN THE PARTNERSHIP

10.1 In General. A Limited Partner may sell, transfer, assign, or subject to a security interest any or all of the Interests owned by him or her; provided, however, that:

10.1.1 Such sale, transfer, assignment, or security interest is not with respect to a fraction of an Interest, and

10.1.2 Such Limited Partner and his purchaser, transferee, or assignee execute, acknowledge, and deliver to the General Partner such instruments of transfer and assignment with respect to such transaction as are in form and substance satisfactory to the General Partner; and

10.1.3 The resulting owner of the Interest shall be a physician or health care professional licensed in the state of Tennessee or an affiliate thereof; and

10.1.4 Such Limited Partner pays the Partnership a transfer fee which is sufficient to pay all reasonable expenses of the Partnership in connection with such transaction; and

10.1.5 Provide further, that such purchaser, transferee, assignee, or holder of such security interest shall not become a Limited Partner within the meaning of the Act unless the General Partner consents in writing to such person becoming a substituted Limited Partner.

10.2 Substituted Limited Partners. If the General Partner consents to the admission of a person as a substituted Limited Partner within the meaning of the Act, and such person:

10.2.1 Elects to become a substituted Limited Partner by delivering a written notice of such election to the General Partner; and

10.2.2 Executes and acknowledges such other instruments as the General Partner may deem necessary or advisable to effect the admission of such person as a substituted Limited Partner, including, without limitation, the written acceptance and adoption by such person of the provisions of this Agreement; and

10.2.3 Pays a transfer fee to the Partnership which is sufficient to cover all reasonable expenses connected with admission of such person as a substituted Limited Partner within the meaning of the Act, including, without limitation, the cost of amending this Agreement and taking any other action required by the Act; and

10.2.4 Then the General Partner shall amend this Agreement and shall take all other steps which, in the opinion of the General Partner, are reasonably necessary to admit such person as a substituted Limited Partner under Section 8.6 hereof and the Act. The General Partner shall take such action not later than 90 days following a compliance with the conditions of this Section 10.2. Such person shall become a substituted Limited Partner within the meaning of the Act on the date such person is deemed to be a Limited Partner under Section 8.6 hereof. The General Partner shall not be required to consent to the admission of any person as a substituted Limited Partner if, in its opinion, such consent and substitution would result in the Partnership being treated for federal income tax purposes as an association taxable as a corporation or would constitute a violation of any applicable federal or state law pertaining to securities regulation.

10.3 Additional Limited Partners. By an affirmative vote of a simple majority of the Limited Partners, the General Partner may, beginning at the closing of the offering of Interests, approve the admission of additional Limited Partners, by the sale to them of authorized but unissued Interests. The sale of such Interests may be on such terms as the General Partner deems fair, equitable, and in the best interests of the Partnership. No more than 25 Interests per year may be sold pursuant to this Section 10.3, and no more than 450 Interests may be outstanding after any such sale. Any sale pursuant to this Section 10.3 must be made pursuant to all applicable state and federal securities laws.

10.4 Purchase of Interests by the General Partner. The General Partner may acquire one or more Interests, and, if with respect to such additional Interest or Interests the General Partner becomes a Limited Partner within the meaning of the Act, the General Partner shall, with respect to such Interest or Interests, enjoy all rights and be subject to all of the obligations and duties of a Limited Partner. Any Interests owned by the General Partner may be sold by the General Partner, on whatever terms and conditions it deems appropriate, to any qualified investor so long as such sale does not violate any applicable federal or state law pertaining to securities regulation.

10.5 Valuation of Interests. For purposes of Section 10.6 hereof, the fixed value (the "Fixed Value") of each Interest shall be an amount determined by the General Partner pursuant to this Section 10.5. The General Partner shall make available to each of the Limited Partners, upon request, the Fixed Value of each Interest on or before April 30 of each year. The Fixed Value of an Interest shall be the lesser of (i) an

amount equal to two times the Limited Partner's Capital Contribution (ii) the sum of the present value of a stream of annual payments made on each April 30 during the remaining term of any revenue producing service contracts or other business activities, with each sum annual payment deemed to be in an amount equal to the average net income per Interest (as shown on the statement of income and loss prepared annually by the Partnership) during the three immediately preceding calendar years. If the Partnership has been in existence for less than three calendar years, such income per Interest for the years during which the Partnership was in existence. The present value of such deemed payments shall be determined using a discount rate equal to 120% of the applicable federal rate (as determined under Internal Revenue Code Section 1274) for obligations of a maturity equal to the remaining terms of the Agreement.

10.6 Transfer Upon Death, Disability, Retirement, or Departure from the Area. Upon the death, disability, retirement, or departure from the area of a Limited Partner, the Limited Partner or the estate of such Limited Partner must, within two years of the death, disability, retirement, or departure from the area, either sell the Interest or Interests owned by such Limited Partner to another qualified investor, subject to the General Partner's right to direct the sale of an Interest, or sell the Interest or Interests to the General Partner for an amount equal to the Fixed Value of such Interest or Interests.

10.7 Option to Buy Limited Partnership Interest; Resale. By direction of the General Partner, the Limited Partnership shall have the following option to purchase the Partnership Interests of the Limited Partners, or any of them. The General Partner, in its sole discretion, may cause the Limited Partnership to exercise the option in accordance with Section 10.7.

10.7.1 The General Partner shall have the right, but not the obligation, at its option, to cause the Limited Partnership to purchase the Interest of any Limited Partner who is a person licensed under the Tennessee Business and Professions Code, or any chapter thereunder ("Licensed Person"), in the event (a) any Tennessee or federal legislation is enacted which renders it unlawful for a Limited Partner who is a Licensed Person to refer patients to the facility in which the Project is carried on or (b) a court, or a state or federal agency charged with interpreting the Tennessee Business and Professions Code determines that the receipt of Partnership distributions by a Licensed Person constitutes a referral fee prohibited by the Code. The period in which this option may be exercised shall begin upon the effective date of any such legislation, or the date the General Partner has actual notice of any such interpretation, and shall continue for a period of 180 days after such date.

10.7.2 The option price shall be equal to (a) the original issuance price, plus (b) interest, calculated from the date of issuance, at the rate of 9% compounded annually, less (c) 80% of the sum of the amounts of cash distributed with respect to the Partnership Interest. For example, if the option were exercised one year after the issuance of two Units of Partnership Interest, and $2,000 cash was distributed, the option price would be $2,000 + $2,000(0.09) - $2,000(.8) = $580.

Payment of the option price shall be made in six monthly installments at no interest. However, such installments may be prepaid at any time in the sole discretion of the General Partner.

10.7.3 The General Partner shall have the additional right, in its sole discretion, to sell and reissue any Unit or Units purchased by the Limited Partnership pursuant to this Section 10. The purchaser of such reissued Unit or Units, upon (1) payment of 100% of the Reissue Purchase Price to the Limited Partnership, and (2) execution of an Amended Limited Partnership Agreement and an Amended Certificate of Limited Partnership, shall become a Limited Partner. The Reissue Purchase Price shall be determined by the General Partner in its sole discretion, except that in no event shall the Reissue Price be less than the option price for such Unit paid to the former Limited Partner pursuant to Section 10.7.2, as applicable. The General Partner and the purchaser, under this Section 10.7.3, shall comply with all applicable securities laws in connection with the sale and reissuance.

XI. RESIGNATION OR REMOVAL OF THE GENERAL PARTNER; ELECTION OF SUBSTITUTED GENERAL PARTNER

11.1 Resignation of the General Partner. Subject to the provisions of Sections 11.4 and 12.2 of this Agreement, the General Partner may resign as such by written notice given in accordance with Section 11.3 of this Agreement.

11.2 Removal of the General Partner. Subject to the provisions of Sections 11.4 and 12.2 of this Agreement, the General Partner shall be removed and cease to be the General Partner of the Partnership:

11.2.1 For good cause (which shall include, but not be limited to, any failure to comply with any material covenant or agreement contained in this Agreement) upon the vote of Limited Partners holding an aggregate Limited Partnership Percentage greater than 90% to remove the General Partner and delivery of written notice of such vote as provided in Section 11.3 of this Agreement; or

11.2.2 Immediately upon the dissolution of the General Partner or upon the adjudication that such General Partner is insolvent or bankrupt.

11.3 Notice of Resignation or Removal. Written notice of the resignation of the General Partner shall be given by the General Partner to the Limited Partners, and written notice of the removal of the General Partner shall be given by the Limited Partners voting to remove the General Partner pursuant to Section 11.2.1 of this Agreement to the General Partner and the other Limited Partners. Such notice shall set forth the day upon which the resignation or removal is to become effective, which date in the case of resignation of the General Partner and in the case of removal pursuant to Section 11.2.1 of this Agreement shall not be less than 90 days after such notice is given to the party or parties being notified, unless a substituted General Partner is elected pursuant to Section 11.5 of this Agreement. Notice for removal of the General Partner shall set forth the reasons for such removal.

11.4 Liability of the General Partner after Resignation or Removal. If the General Partner resigns or is removed in accordance with the provisions of this Agreement, its liability as a General Partner shall cease and the Partnership shall promptly take all steps reasonably necessary under the Act to cause such cessation of liability; provided, however, that if such resignation or removal causes a dissolution of the Partnership, the General Partner shall remain the General Partner of the Partnership for purposes of winding up of the Partnership pursuant to Section 12.2 of this Agreement, unless a substitute General Partner is elected pursuant to Section 11.5 of this Agreement. Upon resignation or removal, the General Partner shall receive any unpaid Available Cash Flow allocated to his Capital Account and shall thereafter forfeit to the Partnership its Interest in the Partnership as the General Partner, which Interest will be allocated to a substitute General Partner.

11.5 Election of Substitute General Partner. If the General Partner resigns or is removed pursuant to this Agreement, 90% of the Limited Partnership Interest may elect a substitute General Partner. Such election must occur before the effectiveness of such resignation or removal. The initial substitute General Partner or any other person elected shall not become a General Partner until such resignation or removal is effective and such person has executed a copy of this Agreement as required by the Act and had his or her signature thereto acknowledged.

XII. DISSOLUTION AND WINDING UP OF THE PARTNERSHIP

12.1 Dissolution of the Partnership. The resignation or removal of the General Partner shall cause a dissolution of the Partnership unless, within 90 days thereafter, a substitute General Partner shall be elected hereunder to continue the business of the Partnership, in a reconstituted form if necessary, and subject to all the terms of this Agreement. The Partnership shall also be dissolved upon (a) the vote to do so of Limited Partners holding an aggregate Limited Partnership Percentage greater than 90% and delivery by the Limited Partners voting to dissolve of written notice of such vote to the General Partner and other Limited Partners, (b) the transfer in any consecutive 12-month period of greater than 50% of the Interests, or (c) the expiration of the term of the Partnership. In no event shall the death of any Limited Partner result in dissolution of the Partnership. In the event of the death of any Limited Partner, the personal representative of the deceased Limited Partner in the Partnership shall succeed to the Interest of the deceased Limited Partner in the Partnership subject to the rights of any assignees of the deceased Limited Partner in and to such Interest, and subject to the provisions of this Agreement.

12.2 Winding Up of the Partnership. Upon the dissolution of the Partnership, the General Partner shall take full account of the Partnership's assets and liabilities and the assets shall be liquidated as promptly as is consistent with obtaining the fair value thereof. The proceeds therefrom, to the extent sufficient therefor, shall be applied and distributed as provided in Section 17-804 of the Act; provided, however, that after payment of or creating adequate reserves to provide for all Partnership debts, obligations, and liabilities, the assets of the Partnership, if any, shall be treated as if sold for their Fair Market Value and allocations and distributions shall be made pursuant to

Section XIII hereof. All Partnership assets shall be distributed by the later of (i) the last day of the tax year of the liquidation as defined in Treasury Regulation 1.704(b), or (ii) 90 days after the liquidation.

XIII. BOOKS OF ACCOUNT, ACCOUNTING, REPORTS, FISCAL YEAR, BANKING AND TAX ELECTION

13.1 Books of Account. The Partnership's books and records (including a current list of the names and addresses of all Limited Partners) and an executed copy of this Agreement, as currently in effect, shall be maintained at the office of the Partnership at 311 22nd Avenue North, Nashville, Tennessee 37203, and each Partner shall have access thereto at all reasonable times. The books and records shall be kept or caused to be kept by the General Partner using an appropriate method of accounting consistently applied and shall reflect all Partnership transactions and be appropriate and adequate for the Partnership's business. The General Partner shall also keep or cause to be kept adequate Federal Income Tax records using an appropriate method of accounting applied on a consistent basis.

13.2 Financial Reports. As soon as reasonably practicable after the end of each fiscal year, but not later than March 31st of the next succeeding year, each Partner shall be furnished with a copy of a balance sheet of the Partnership as of the last day of such fiscal year and statements of income or loss and source and application of funds of the Partnership for such year certified by a firm of independent accountants selected by the General Partner, and the report and opinion of such firm with respect to such financial statements. In addition, the Partnership will furnish to the Limited Partners unaudited quarterly summaries of its operations. All such financial statements shall be prepared on a cash basis of accounting in accordance with generally accepted accounting principles consistently applied. The Partnership shall also furnish to each Partner not later than March 31st of each year an unaudited statement of cash flow of the Partnership for such year and a statement showing the amounts allocated to or allocated against such Partner pursuant to this Agreement during or in respect of such year, and any items of income, deduction, credit, or loss allocated to such Partner for purposes of the Internal Revenue Code of 1986. The Partnership will also furnish to each Partner a copy or summary of all state and/or local tax returns which are filed by the Partnership.

13.3 Annual Reports. The annual financial statements provided for in Section 13.2 of this Agreement shall be accompanied by a report in reasonable detail, containing a description of the activities of the Partnership during such year. Such report shall set forth the distributions to the Limited Partners during such year and shall separately identify distributions to the Limited Partners during such year and shall separately identify distributions from (a) cash flow from operations during the year, (b) cash flow from prior periods, and (c) proceeds from any refinancing or disposition by the Partnership at the end of such year. In addition, such annual report shall contain a complete statement of all compensation and fees paid or accrued by the Partnership to the General Partner and its affiliates, together with a description of any new agreements with affiliates.

13.4 Fiscal Year. The fiscal year of the Partnership shall be the calendar year.

13.5 Banking. All funds of the Partnership shall be initially deposited in a separate bank account or accounts or in an account of a savings and loan association as shall be determined by the General Partner, but such funds may be invested as provided in Section 9.1.6 of this Agreement.

13.6 Tax Election. Upon the transfer of an Interest in the Partnership or in the event of a distribution of the Partnership's property, the General Partner may, but is not obligated to, cause the Partnership to elect pursuant to Section 754 of the Internal Revenue Code of 1986, to adjust the basis of the Partnership's property as allowed by Sections 734(b) and 743(b) thereof.

13.7 Tax Returns; Tax Matters Partner. The General Partner shall, for each fiscal year, file on behalf of the Partnership with the IRS a Partnership Return within the time prescribed by law (including any extensions) for such filing. The General Partner shall also file on behalf of the Partnership such state and/or local income tax returns as may be required by law.

XIV. POWER OF ATTORNEY

14.1 Appointment of Attorney-in-Fact. Each Limited Partner, pursuant to such Limited Partner's execution of a Subscription Agreement pertaining to his purchase of Interests, hereby makes, constitutes, and appoints the General Partner with full power of substitution and resubstitution, his agent and attorney-in-fact to execute this Agreement and to sign, execute, certify, acknowledge, and file for record any other instruments which may be required of the Partnership or of the Limited Partners by law, including, but not limited to, amendments to or cancellations of this Agreement or of the Certificate. Each Limited Partner authorizes such attorney-in-fact to take any further action which such attorney-in-fact shall consider necessary or advisable in connection with the foregoing, including the sale or disposition of all or substantially all of the Partnership's assets pursuant to Section 9.4.2(a), hereby giving such attorney-in-fact full power and authority to act to the same extent as if such Limited Partners were himself personally present, and hereby ratifying and confirming all that such attorney-in-fact shall lawfully do or cause to be done by virtue hereof.

14.2 Effect of Power. The power of attorney granted pursuant to Section 14.1 of this Agreement:

14.2.1 Is a special power of attorney coupled with an Interest, is irrevocable, and shall survive the death, insanity, or incapacity of the granting Limited Partner; and

14.2.2 May be exercised by such attorney-in-fact for each Limited Partner by listing all of the Limited Partners executing any agreement, certificate, instrument, or document with the single signature of such attorney-in-fact as attorney-in-fact for all of them; and

14.2.3 Shall survive the delivery of an assignment by a Limited Partner of the whole or a portion of his Interest in the Partnership, except that where the purchaser, transferee, or assignee thereof is to be admitted as a substituted Limited Partner, the power of attorney shall survive the delivery of such assignment for the sole purpose of enabling such attorney-in-fact to execute, acknowledge, and file any such agreement, certificate, instrument, or document necessary to effect such substitution.

XV. LIABILITY OF THE GENERAL PARTNER

15.1 Return of Capital Contribution. Anything in this Agreement to the contrary notwithstanding, the General Partner shall not be individually liable for the return of the Capital Contributions of the Limited Partners, or any portion thereof, it being expressly understood that any such return shall be made solely from Partnership assets.

15.2 No Liability for Actions. The doing of any act or the failure to do any act by the General Partner shall not subject the General Partner to any liability to the Partnership or the Partners, except for gross negligence or willful malfeasance.

XVI. MISCELLANEOUS

16.1 Notices. Except as otherwise provided in this Agreement, any notice, payment, demand, or communication required or permitted to be given by any provision whom it is authorized to be given, or is sent by mail or telegraph, as follows: if to the General Partner, as its address set forth in the first paragraph of this Agreement, or to such other address as the General Partner may from time to time specify by written notice to the Limited Partners; and if to a Limited Partner, at such Limited Partner's address as so stated on his or her subscription agreement, or at such other address as the Limited Partner may from time to time specify by written notice to the General Partner and all other Limited Partners. Any such notice shall be deemed to be given as of the date so delivered, if delivered personally, or as of the date which the same was deposited in the United States mail, postage, prepaid, addressed, and sent as aforesaid.

16.2 Section Captions. Section and other captions contained in this Agreement are for reference purposes only and are in no way intended to describe, interpret, define or limit the scope, extent, or intent of this Agreement or any provision hereof.

16.3 Severability. Every provision of this Agreement is intended to be severable. If any term or provision of this Agreement is illegal or invalid for any reason whatsoever, such illegality or invalidity shall not affect the validity of the remainder of this Agreement.

16.4 Amendments. Amendments to this Agreement or to the Certificate may be made in the following manner.

16.4.1 Amendments to this Agreement or the Certificate may be proposed by the General Partner. Following such proposal, the General Partner shall submit to the Limited Partners a verbatim statement

of any proposed amendment and may include in any such submission their recommendation as to the proposed amendment. The General Partner shall seek the written vote of the Limited Partners on the proposed amendment or shall call a meeting of the Partners pursuant to Section 16.5 of this Agreement to vote thereon and to transact any other business permitted by the Act to be transacted by the Limited Partners that they may deem appropriate. For purposes of obtaining a written vote, the General Partner may require response within a specified time, but not less than 30 days, and failure to respond in such time shall constitute a vote which is consistent with the General Partner's recommendation with respect to the proposal. A proposed amendment shall be adopted and effective as an amendment to this Agreement or the Certificate if it receives the affirmative vote of the Limited Partners holding an aggregate Limited Partnership Percentage of greater than 50%; provided, however, that amendments to Section 11.2, 11.4, and 12.1 shall only be effective upon receiving the affirmative vote of Limited Partners holding an aggregate Limited Partnership Percentage of greater than 90%.

16.4.2 In addition to any amendments otherwise authorized herein, the General Partner may, without obtaining the consent of the Limited Partners, amend this Agreement or the Certificate from time to time as specified below:

(a) To add to the representations, duties, or obligations of the General Partner or their affiliates herein, for the benefit of the Limited Partners;

(b) To cure any ambiguity, to correct or supplement any provision herein or therein which may be inconsistent with any other provision herein, or to make any other provisions with respect to matters or questions arising under this Agreement or the Certificate, as the case may be, which will not be inconsistent with the provisions of this Agreement or the Certificate as the case may be, provided that the Partnership receives a written opinion of independent counsel that such amendment does not adversely effect the Interests of the Limited Partners; and

(c) As necessary in the opinion of counsel to the Partnership for the allocations of taxable income and loss contained herein to be respected for Federal income tax purposes, provided that no such amendment shall materially increase the obligations of the Limited Partners hereunder or materially dilute their rights under this Agreement.

16.5 Meetings and Means of Voting. Meetings of the Partners may be called by the General Partner, or Limited Partners holding an aggregate Limited Partnership Percentage of at least 25%, for any matter specified in Sections 9.4, 11.2, 11.5, or 12.1 of this Agreement. The call shall state the nature of the business to be transacted. Notice of any such meeting shall be delivered by the General Partner within ten days after such notice. Partners may vote in person or by proxy at such meeting. Whenever the vote or consent of Partners is permitted or required under this Agreement, such vote or consent may be given at a meeting of Partners or may be given in writing in accordance with the procedure for obtaining written votes prescribed in Section 16.4.1 of this Agreement.

16.6 Right to Rely Upon the Authority of the General Partner. No person dealing with the General Partner shall be required to determine its authority to make any commitment or undertaking on behalf of the Partnership, nor to determine any fact or circumstance bearing upon the existence of its authority. In addition, no purchaser of any property of the Partnership shall be required to determine the sole and exclusive authority of the General Partner to sign and deliver on behalf of the Partnership any such instrument of transfer, or to see to the application or distribution of revenues or proceeds paid or credited in connection therewith, unless such purchasers shall have received written notice from the Partnership affecting the same.

16.7 Delaware Law. The laws of the State of Delaware shall govern the validity of this Agreement, the construction of its terms, and the interpretation of the rights and duties of the parties hereto.

16.8 Waiver of Action for Partition. Each Partner irrevocably waives, during the term of the Partnership and during the period of its liquidation following any dissolution, any right to maintain any action for partition with respect to any of the assets of the Partnership.

16.9 Counterpart Execution. This Agreement may be executed in one or more counterparts all of which together shall constitute one and the same Agreement.

16.10 Parties in Interest. Except as provided in Section 10 of this Agreement, this Agreement shall be binding upon the parties hereto and their successors, heirs, devisees, assigns, legal representatives, executors, and administrators.

16.11 Integrated Agreement. This Agreement constitutes the entire understanding and agreement among the parties hereto with respect to the subject matter hereof, and there are no agreements, understandings, restrictions, representations, or warranties among the parties other than those set forth herein or herein provided for.

XVII. CERTIFICATE OF LIMITED PARTNERSHIP

17.1 This document shall constitute the basis for the Certificate of Limited Partnership. The General Partner shall cause the Certificate of Limited Partnership to be filed in the office of the Secretary of State pursuant to the Delaware Revised Uniform Limited Partnership Act.

XVIII. REPRESENTATIONS OF THE LIMITED PARTNERS

18.1 Each of the Limited Partners, by executing this Agreement, makes the following representations, each of which may be relied upon by the General Partner in forming the Limited Partnership:

18.2 I understand that in forming this Limited Partnership and offering and selling Partnership Interests therein, the General Partner, in reliance upon an exemption from the registration and prospectus delivery requirements of the Act has not registered the Partnership Interests with the Securities and Exchange Commission nor obtained a

permit from the Tennessee Department of Commerce and Insurance. Each exemption requires that the Partnership Interests be offered and sold in transactions not involving a public offering. I understand that the representations I make herein have been and will be relied upon by the General Partner and its attorney in concluding that the offer and sale of the Partnership Interests are transactions not involving a public offering. I further understand that neither the Securities and Exchange Commission nor the Tennessee Department of Commerce and Insurance have reviewed the Limited Partnership nor have they made any findings with respect to the offer or sale of the Partnership Interests or the fairness of the investment.

18.3 I understand that the General Partner has not requested a tax ruling from the United States Internal Revenue Service nor an opinion of counsel with respect to the taxability of the Limited Partnership as such or the treatment for tax purposes of certain expenses or expenditures of the Limited Partnership, and no assurances have been made that the treatment which the Limited Partnership intends to or does use with respect to such items will be accepted by the United States Internal Revenue Service upon examination and audit.

18.4 I have received and hereby acknowledge the Offering Memorandum dated April 6, 1988 including the financial information and the Forecasts which are only definitive. The General Partner has made no representations or warranties to me concerning the Limited Partnership. My accountant and my attorney have been given the opportunity to review all documents pertaining to this transaction.

18.5 I do understand that this investment is, by its nature, speculative and that because of the speculative nature, I could sustain a loss of 100% of my investment. I further understand that the investment in my Partnership Interest, because of the severe restrictions on transfer imposed upon the Partnership Interest by United States and state securities laws and this Agreement, is an investment with limited liquidity and that I may not be able to quickly liquidate my investment in case of emergency or receive fair value therefor in a forced sale.

18.6 Either:

18.6.1 I have had substantial investment experience with securities, such as stocks and bonds and am familiar with such investments; or

18.6.2 I am a personal friend of or have a preexisting business or personal relationship with the General Partner or its officers, directors, or controlling person.

18.7 I am over the age of 21 years, and my residence address is as set forth beneath my typed or printed name on the signature page of this Agreement.

18.8 I represent that at the time the offer of the Partnership Interest was made to me and at the time I executed this Agreement, I intend to and will acquire my Partnership Interest for my own account for investment purposes only without any intention to distribute or resell it.

18.9 I represent that I will not transfer, assign, sell, pledge or dispose of all or any part of my Partnership Interest to any person other than in accordance with this Agreement.

18.10 I recognize that the General Partner and each of the other Limited Partners have relied upon the foregoing representations in connection with the execution of this Agreement and I agree to indemnify each and every one of them for any loss or costs that may be incurred because of any misrepresentations.

IN WITNESS WHEREOF, this Agreement of Limited Partnership has been executed as of the date first written above.

GENERAL PARTNER:

QUANTUM CORPORATION

By: _____
Charles L. Robinette, Jr., M.D.
Vice President

ORIGINAL LIMITED PARTNER:

Signature: _____

Name: _____
Please Print

Address: _____

_____

_____

APPENDIX D

SUBSCRIPTION AGREEMENT

NASHVILLE IMAGING CENTER, L.P.

1. Subscription. The subscriber whose name appears on the signature page (the "Subscriber") hereby applies to become a Limited Partner in Nashville Imaging Center, L.P., a Delaware Limited Partnership (the "Partnership"), and to purchase the number of Units of Limited Partnership Interest in the Partnership (the "Units) stated on the Signature Page in accordance with the terms and conditions of the Limited Partnership Agreement (the "Partnership Agreement"), a copy of which is attached as Appendix C to the Partnership's Offering Memorandum dated April 6, 1988 (the "Memorandum").

2. Adoption of Limited Partnership Agreement. The Subscriber hereby specifically approves, ratifies, and agrees to be bound by each and every provision of the Partnership Agreement with the same force and effect as if the Subscriber's signature was executed on the Partnership Agreement.

3. Representations by Subscriber. By executing this Subscription Agreement, the undersigned makes certain acknowledgements, representations, and warranties ("statements") to the Partnership and the General Partner. If the undersigned Subscriber consists of one or more individuals, each statement is true as to each such individual. If the subscriber is an entity (a corporation or a partnership), each statement is true as to each principal of the entity, and if the Subscriber is a trust, each statement is true as to each beneficiary of the trust. As an inducement to the Partnership to accept this offer, the Subscriber hereby represents, warrants, and covenants that:

(a) The Subscriber is at least 21 years of age and maintains his or her principal residence in the State of Tennessee.

(b) This is a financially suitable investment for him or her in that: (i) the Subscriber has an annual gross income of at least $30,000, a net worth (excluding home, home furnishings, and personal use automobiles) of at least $30,000, (ii) has a net worth (excluding home, home furnishings and personal use automobiles) of at least $50,000, or (iii) that he or she meets the requirements of an Accredited Investor as outlined in the Offering Memorandum under "SUITABILITY STANDARDS - WHO MAY INVEST".

(c) The Subscriber has received and reviewed the Memorandum and all Appendices attached thereto, as supplemented and/or amended to the date hereof, and has had an opportunity to ask such questions and inspect such documents as the Subscriber has reasonably requested concerning the Partnership. The Subscriber entered into this Subscription Agreement with a knowledge and understanding of the investment and its risks, and in making this subscription has relied solely upon the Offering Memorandum and the Appendices attached thereto, his or her own independent investigation and his or her independent advisors, and has not relied upon any other offering materials or oral representations.

(d) The Subscriber understands that the Units have not been registered under the Securities Act of 1933, as amended (the "Act") or registered or qualified ("registered") under any state securities laws in reliance on certain exemptions from such registration.

(e) The Subscriber is purchasing the Units for investment for his or her own account for investment purposes and not with a view to resell or otherwise distribute the Units.

(f) The Subscriber agrees that the undersigned will not sell or otherwise transfer or dispose of any Units or any portion thereof unless: (i) such Units are registered under the Act and any applicable state securities law or the undersigned obtains an opinion of counsel which is satisfactory to the Partnership that such Units may be sold in reliance on an exemption from such registration requirements; and (ii) the transfer is otherwise made in accordance with law and with the terms described in the Partnership Agreement.

(g) The Subscriber understands that: (i) the Partnership has no obligation or intention to register any Units for resale or transfer under the Act or any state securities laws or to take any action (including the filing of reports or the publication of information required by Rule 144 under the 1933 Act) which would make available any exemptions from the registration requirements of any such laws; and (ii) the undersigned therefore may be precluded from selling or otherwise transferring or disposing of any Units for an indefinite period of time or at any particular time.

(h) The financial condition of the Subscriber is presently adequate to bear the substantial economic risks of this investment, including the total loss of this investment, and he or she, either alone or together with his or her independent advisors, has such knowledge and experience in investment, tax, medical technology and business matters as to be capable of evaluating the merits and risks of this investment.

(i) All communications and information, written or oral, concerning the Units, the Subscriber's offer to become a Limited Partner, and his or her acceptance as Limited Partner, have been directed to persons in and have been received in the State of Tennessee.

(j) The Subscriber understands that the General Partner in its sole discretion may accept or reject this Subscription Agreement in whole or in part.

(k) The Subscriber understands that the Units are being offered and sold in reliance on specific exemptions from the registration requirements of federal and state law and that the Partnership is relying upon the truth and accuracy of the representations, warranties, agreements, acknowledgements and understandings set forth in this Subscription Agreement in connection with those exemptions.

(l) The Subscriber represents, warrants, and agrees that, if the undersigned is an entity or is acquiring the Units in a fiduciary capacity: (i) the above representations, warranties, and covenants shall be deemed to have been made on behalf of each person for whom such Unit is being acquired; (ii) the name of each such person is indicated below under the subscriber's name; and (iii) such further information as the Partnership may request shall be furnished regarding each such person.

4. Appointment of Attorney-In-Fact. Upon the acceptance of this Subscription Agreement by the General Partner, the undersigned hereby constitutes and appoints Charles L. Robinette, Jr., M.D., Grover R. Smith, Jr., M.D., and/or Charles T. Faulkner, M.D., (the "Attorney"), with full power of substitution, the undersigned's attorney-in-fact for the purpose of executing, filing, and recording on behalf of the undersigned all certificates and all other instruments which the General Partner may deem necessary or appropriate to form, qualify, continue, dissolve or terminate the Partnership, or which are contemplated by the Limited Partnership Agreement, in all jurisdictions in which the Partnership does business, including but not limited to, the Limited Partnership Agreement (which includes the grant of powers of attorney as set forth therein), the Certificate of Limited Partnership and amendments thereto and fictitious business name filings.

The foregoing grant of authority:

(a) Is a Special Power of Attorney coupled with an Interest, is irrevocable, and shall survive the death, disability, dissolution, bankruptcy or insolvency of the undersigned;

(b) May be exercised by the Attorney by listing the Subscriber together with other Limited Partners executing any instrument with a single signature of the Attorney acting as attorney-in-fact for all of them; and

(c) Shall survive the delivery of an assignment by a Limited Partner of the whole or any portion of his or her Interests in the Partnership, except that where the assignee has been approved by the General Partner for admission to the Partnership as a Limited Partner, the power of attorney shall survive the delivery of such assignment for the sole purpose of enabling the Attorney to execute, acknowledge and file any instruments necessary to effect such transfer.

5. Indemnification. The undersigned hereby indemnifies and holds harmless the Partnership, the General Partner, and its affiliates from and against all damages, losses, costs and expenses (including reasonable attorneys' fees and expenses) which they may incur by reason of the failure of the undersigned to fulfill any of the terms or conditions of this subscription Agreement, or by reason of any breach of the representations, warranties and covenants of the undersigned made in this Subscription Agreement or in connection with the Partnership Agreement or in any document provided by the undersigned to the Partnership or the General Partner in connection with the Partnership.

NASHVILLE IMAGING CENTER, L.P.

PLEASE READ ENTIRE AGREEMENT BEFORE SIGNING

I/We wish to subscribe for _____ Units of Limited Partnership Interest at $1,000 per Unit, representing a subscription for $_____. Attached is my/our check for $_____ ($1,000 per Unit). I/We understand that a minimum purchase of two Units is required. I/We hereby specifically approve, ratify and agree to be bound by each and every representation, warranty and covenant that appears in this Subscription Agreement and Signature Page. By signing below, I/we grant to the General Partner of the Partnership an irrevocable power of attorney, with full power of substitution, to sign, file and record on behalf of the undersigned all documentation which the General Partner may deem necessary or appropriate as attorney and to sign and file all documentation on behalf of the undersigned as described in Paragraph 4 of the Subscription Agreement including, but not limited to, the Partnership's Certificate of Limited Partnership.

IN WITNESS WHEREOF, the Subscriber has executed this Subscription Agreement and Signature Page.

X _____
Authorized Signature(s) of Subscriber(s)

_____
Typed or Printed Name(s)

(Date) _____, 1988

CHECKS SHOULD BE MADE PAYABLE TO "NASHVILLE IMAGING CENTER, L.P.", a Delaware Limited Partnership. Deliver this Subscription Agreement and Signature Page, completed and signed, along with your cash payment for the Units to be purchased, to the General Partner:

Quantum Corporation
311 22nd Avenue North
Nashville, Tennessee 37203

REGISTRATION: _____
Print Name(s) in which Limited Partnership Interest(s) are to be Registered

SOCIAL SECURITY/TAXPAYER ID NO. _____

OCCUPATION: _____

RESIDENCE ADDRESS:

_____
Street

_____
City State Zip

BUSINESS ADDRESS:

_____
Street

_____
City TN State Zip

HOME PHONE: _____

BUSINESS PHONE: _____

Name, address, telephone number, and occupation of my PROFESSIONAL ADVISER who advised Subscriber in connection with this investment:

_____

_____

_____

LEGAL FORM OF OWNERSHIP (Check One):

Individual _____ Corporation _____ Partnership _____ Trust _____

ACCREDITED INVESTOR: I qualify as an Accredited Investor:

Yes _____ No _____

ACCEPTED: NASHVILLE IMAGING CENTER, L.P.

BY: QUANTUM CORPORATION, General Partner

BY: _____ Dated: _____
Charles L. Robinette, Jr., M.D.
Vice President

NASHVILLE IMAGING CENTER, L.P.

PLEASE READ ENTIRE AGREEMENT BEFORE SIGNING

I/We wish to subscribe for _____ Units of Limited Partnership Interest at $1,000 per Unit, representing a subscription for $_____. Attached is my/our check for $_____ ($1,000 per Unit). I/We understand that a minimum purchase of two Units is required. I/We hereby specifically approve, ratify and agree to be bound by each and every representation, warranty and covenant that appears in this Subscription Agreement and Signature Page. By signing below, I/we grant to the General Partner of the Partnership an irrevocable power of attorney, with full power of substitution, to sign, file and record on behalf of the undersigned all documentation which the General Partner may deem necessary or appropriate as attorney and to sign and file all documentation on behalf of the undersigned as described in Paragraph 4 of the Subscription Agreement including, but not limited to, the Partnership's Certificate of Limited Partnership.

IN WITNESS WHEREOF, the Subscriber has executed this Subscription Agreement and Signature Page.

X _____
Authorized Signature(s) of Subscriber(s)

_____
Typed or Printed Name(s)

(Date) _____, 1988

CHECKS SHOULD BE MADE PAYABLE TO "NASHVILLE IMAGING CENTER, L.P.", a Delaware Limited Partnership. Deliver this Subscription Agreement and Signature Page, completed and signed, along with your cash payment for the Units to be purchased, to the General Partner:

Quantum Corporation
311 22nd Avenue North
Nashville, Tennessee 37203

REGISTRATION: _____
Print Name(s) in which Limited Partnership Interest(s) are to be Registered

SOCIAL SECURITY/TAXPAYER ID NO. _____

OCCUPATION: _____

RESIDENCE ADDRESS:

_____
Street

_____ TN _____
City State Zip

BUSINESS ADDRESS:

_____
Street

_____ TN _____
City State Zip

HOME PHONE: _____ **BUSINESS PHONE:** _____

Name, address, telephone number, and occupation of my PROFESSIONAL ADVISER who advised Subscriber in connection with this investment:

_____

_____

_____

LEGAL FORM OF OWNERSHIP (Check One):

Individual _____ Corporation _____ Partnership _____ Trust _____

ACCREDITED INVESTOR: I qualify as an Accredited Investor:

Yes _____ No _____

ACCEPTED: NASHVILLE IMAGING CENTER, L.P.

BY: QUANTUM CORPORATION, General Partner

BY: _____ Dated: _____
Charles L. Robinette, Jr., M.D.
Vice President

Attachment A

AGREEMENT FOR GENERAL SURGERY SERVICES
BETWEEN
MINNHEALTH, P.A.
AND
_____

DATE: April 1, 1988

PARTIES: MinnHealth, P.A.
3220 Bellaire Avenue
White Bear Lake, MN 55110 ("Clinic")

_____
_____
_____
_____ ("Contractor")

RECITALS:

A. Clinic is a Minnesota professional corporation employing individual physicians licensed in Minnesota and qualified under Minnesota law to practice medicine primarily in the area of family practice.

B. Contractor is a Minnesota professional corporation employing individual physicians, each of whom is licensed under Minnesota law in the practice of medicine and each of whom is qualified and is either Board-certified or Board-eligible as a specialist in General Surgery.

C. Clinic is committed to expanding its practice and to making a broader range of services available to its patients, and, in that connection, the parties desire that Contractor provide professional surgical services on behalf of Clinic and its patients.

D. The parties believe that their respective interests and the interests of patients will best be served by entering into the following understandings and agreements.

AGREEMENTS:

NOW, THEREFORE, in consideration of the foregoing and of the mutual promises herein contained, the parties hereto agree as follows:

ARTICLE I

DUTIES

1.1) Professional Services. Contractor shall be available to provide General Surgery services for individual Clinic patients. Contractor shall provide professional coverage adequate to reasonably meet the General Surgery needs of the Clinic's patients; provided, however, that if it should become impractical for Contractor to provide such coverage, or if

such coverage should prove to be inadequate, the parties may mutually agree to a reduced level of professional coverage, and Clinic may arrange for supplemental coverage. The parties have agreed to the schedule of office-based hours detailed in Attachment I and the associated clinic locations.

1.2) Off-Premises Services. The General Surgery services covered by this Agreement shall include services by Contractor at Clinic's facility at the address first stated above, as well as services at other clinic facilities, if any, and all off-premises services on behalf of Clinic's patients, including emergency room services and services performed in any outpatient or freestanding surgery facility. In the case of any such off-premises services, Clinic shall not be responsible for any third-party charges, including but not limited to hospital charges, outside laboratory charges, surgical center charges, etc. Contractor has no authority to obligate Clinic for any such charges and shall not hold itself out as having the authority to do so.

1.3) Non-Exclusivity. It is the intent of the parties to enhance the availability of General Surgery services to Clinic's patients. Contractor may provide, and enter into agreements to provide, General Surgery services to or on behalf of other persons or institutions; provided, however, that provision of such services does not interfere with Contractor's performance of its duties under this Agreement. It is further agreed that Clinic is under no obligation, express or implied, to refer its patients to Contractor, and that Clinic's physicians will in fact refer their patients to those specialists who, in the judgment of Clinic's physicians, are best suited to serve such patients.

ARTICLE 2.

FACILITIES, PERSONNEL, EQUIPMENT AND SUPPLIES

2.1) Facilities. Clinic shall make its facilities available to Contractor for performance of General Surgery office and consultation services under this Agreement. The facilities shall include work space, offices, storage, laboratory facilities and x-ray facilities, such as Clinic shall deem necessary for Contractor's performance of its duties. Clinic shall maintain all such facilities in good order and repair.

2.2) Personnel. Contractor shall provide all necessary professional personnel for the performance of its duties under this Agreement. All such personnel shall be employees of Contractor and shall remain under the direct supervision and control of Contractor. Clinic shall provide all support personnel and services, including nursing personnel, receptionists, technicians, and other support staff. All such personnel shall be employees of Clinic and shall remain under the direct supervision and control of Clinic.

2.3) Equipment and Supplies. Clinic shall provide and maintain all equipment and supplies for the General Surgery services to be provided by Contractor in Clinic's offices and facilities.

ARTICLE 3.

BILLING AND COMPENSATION

3.1) Billing and Collection. Clinic exclusively shall bill for all professional services, including off-premises services, performed by Contractor under this Agreement. Clinic shall also bill for all ancillary and related services, such as laboratory services, x-ray services, facility charges (if any) and the like.

3.2) Compensation to Contractor. Clinic agrees to pay Contractor based upon the Relative Value Index and Conversion Formula detailed in Attachment II for the General Surgery services to be performed under this Agreement, such system being the parties' best estimate of the value of Contractor's services.

3.3) Review and Adjustments. The General Surgery services performed by Contractor under this Agreement shall be accounted for in accordance with the Relative Value Index (Attachment II) and work conversion factors of $29.00 per unit for surgery/procedural work and $2.00 per unit for cognitive work. Clinic agrees to pay Contractor within 75 days of the close of each calendar month based upon the total work units performed multiplied by the work conversion factor.

The work conversion value/factor shall be reviewed annually at the end of each contract year. Any change in the financial arrangement must be agreed to by both parties.

ARTICLE 4.

INDEPENDENT CONTRACTOR STATUS

4.1) Independent Contractors. The parties intend that each of them is and shall remain an independent contractor. This Agreement is not intended to create a partnership or joint venture, nor shall it be construed as such, and neither party shall be liable for any obligation incurred by the other, except as might otherwise be expressly provided herein. Nothing in this Agreement shall be construed as creating a relationship of employer and employee between Clinic and the physicians employed by Contractor, and Clinic shall neither have nor exercise any control or direction over the methods by which Contractor performs its work and services. Contractor shall be solely responsible for the payment of the salaries of its physician employees, including withholding for federal and state taxes, FICA, and any other items for which withholding may be required, either by law or by contracts. No agent, employee or representative of either party shall be construed or deemed to be an agent, employee or representative of the other.

4.2) Separate Operations. Contractor and its physicians shall be free to practice their specialty in any other location or facility, and without any restrictions as to advertising, patient contact, and the like. Contractor shall establish its own hours of operation, provided that they fall within the normal business hours of Clinic.

ARTICLE 5.

INSURANCE

5.1) Contractor Insurance. Contractor shall obtain and keep in force its own policy or policies of malpractice and professional liability insurance under which Contractor and each physician it employs shall be covered for limits of liability reasonable and customary for the type of activities conducted by Contractor for Clinic. Upon request, Contractor shall furnish Clinic with certificates or other satisfactory evidence that such insurance is in effect. Furthermore, Clinic shall obtain and keep in force a policy or policies of general liability and, if necessary, professional liability insurance, covering risks associated with the activities conducted in the facilities of Clinic by all non-physician personnel, including technicians and other support staff employed therein.

ARTICLE 6.

RECORDS

6.1) Patient Records. All patient records shall be exclusively the property of Clinic, provided that upon the request of a patient, copies of patient records shall be promptly provided to Contractor upon payment of the reasonable cost of reproducing such records. Contractor shall also have reasonable access to the patient records maintained by Clinic, when Contractor is called upon to perform General Surgery services on behalf of such patients. This covenant shall survive the termination of this Agreement, and shall be binding upon the parties so long as Clinic maintains records of any patients who were served by Contractor during the tenure of this Agreement.

ARTICLE 7.

TERM AND TERMINATION

7.1) Term. This Agreement shall have a term of one year. Unless terminated as hereinafter provided, this Agreement shall be automatically renewed from year to year thereafter, on the same terms and conditions as are stated herein. The financial terms stated in this Agreement shall be reviewed on an annual basis, at the end of each successive one-year term.

7.2) Events of Termination. This Agreement shall terminate as follows:

a) By mutual written agreement between the parties.

b) By either party upon ninety (90) days written notice provided to the other party.

c) In addition, Clinic shall have the option to terminate this Agreement immediately upon the occurrence of any of the following events:

1) The impairment of Contractor's ability to meet its duties under this Agreement, due to the loss of the services of one or more of Contractor's physicians for any reason or cause, including, but not limited to, termination of employment, resignation, revocation or suspension of the physician's license to practice medicine, or the withdrawal or limitation of staff appointment or privileges at any hospital at which such physician has privileges.

2) Upon the insolvency or bankruptcy of Contractor.

3) Upon the insolvency or bankruptcy of Clinic.

ARTICLE 8.

MISCELLANEOUS

8.1) Entire Agreement. This Agreement constitutes the entire agreement between Clinic and Contractor with respect to the matters addressed herein.

8.2) Amendments. No modification, amendment, or attempted waiver of any of the provisions of this Agreement shall be valid unless in writing and signed by the party against whom the same is sought to be enforced.

8.3) Use of Name. Clinic shall have the right to make promotional use of Contractor's name; or the name or names of the physicians associated with the Contractor, by placing or using such name or names on letterheads, advertisements, or on other promotional material; provided, however, that the use of such name shall always identify the relationship between the parties by identifying the Contractor and/or its physicians as "Consultants in General Surgery" or in some other similar manner.

8.4) Governing Law. This Agreement shall be construed and governed in all respects under and by the laws of the State of Minnesota.

8.5) Construction. In the event that any one or more of the provisions of this Agreement, or any application thereof, shall be found to be invalid, illegal or otherwise unenforceable, the validity, legality and enforceability of the remaining provisions, and any application thereof, shall not in any way be affected or impaired thereby. Captions and section headings are for reference purposes only and shall not in any way be deemed to modify or limit the statements contained in any section or paragraph.

8.6) Binding Effect. This Agreement shall be binding upon and inure to the benefit of the parties, their successors and assigns. No assignment or attempted assignment of this Agreement or any rights or benefits hereunder shall be effective unless the written consent of the other party is first obtained.

8.7) Authority. Each of the undersigned parties warrants that it has full authority to execute this Agreement, and each individual signing the Agreement hereby warrants that he or she has full authority to sign on behalf of the corporation that he or she represents, and to bind such corporation thereby.

IN WITNESS WHEREOF, the parties have executed this Agreement on the date or dates stated below.

MinnHealth, P.A.

By _____

Its President

Date _____

_____

By _____

Its _____

Date _____

ATTACHMENT I

OFFICE COVERAGE/LOCATIONS

Locations:	Required Coverage
1. MinnHealth, P.A. 3220 Bellaire Avenue White Bear Lake, MN 55110 777-8149	1/2 - 1 day per week
2. MinnHealth, P.A. 1814 North St. Paul Road St. Paul, MN 55109 777-8393	1/2 day per week
3. MinnHealth, P.A. 261 North Ruth St. Paul, MN 55119 738-8834	1/2 day per week

ATTACHMENT II

CPT - RELATIVE VALUE UNITS

CPT-4 Code	Description of Service	RVI Units	Conversion Factor	Surgeon Reimbursement
COGNITIVE SERVICES				
OFFICE EXAMS - NEW PATIENTS				
90010	Limited Service	8.5	$2 per unit	$ 17.00
90015	Intermediate Service	12.5	$2 per unit	25.00
90017	Extended Service	17.0	$2 per unit	34.00
90020	Comprehensive Service	21.5	$2 per unit	43.00
OFFICE EXAMS - ESTABLISHED PATIENTS				
90040	Brief	4.5	$2 per unit	9.00
90050	Limited	7.5	$2 per unit	15.00
90060	Intermediate	10.0	$2 per unit	20.00
90070	Extended	13.0	$2 per unit	26.00
CONSULTATIONS (Any Location)				
90600	Limited	8.0	$2 per unit	16.00
90605	Intermediate	12.0	$2 per unit	24.00
90610	Extended	15.0	$2 per unit	30.00
90620	Comprehensive	22.5	$2 per unit	45.00
ADMISSION H & P				
90200	Brief	8.0	$2 per unit	16.00
90215	Intermediate	15.0	$2 per unit	30.00
90220	Comprehensive	21.0	$2 per unit	42.00
DAILY HOSPITAL CARE				
90240	Brief	4.0	$2 per unit	8.00
90250	Limited	6.2	$2 per unit	12.40
90260	Intermediate	10.0	$2 per unit	20.00
90270	Extended	12.5	$2 per unit	25.00

CPT-4 Code	Description of Service	RVI Units	Conversion Factor	Surgeon Reimbursement
PROCEDURAL SERVICES				
19120	Excision benign cyst - breast	5.0	$29 per unit	$ 145.00
19180	Mastectomy - simple	10.4	$29 per unit	304.50
19200	Mastectomy - radical	19.0	$29 per unit	551.00
25111	Excision ganglion - wrist	5.0	$29 per unit	145.00
37730	Vein stripping - unilateral	10.0	$29 per unit	290.00
38100	Spenectomy - elective	16.0	$29 per unit	464.00
44005	Enterolysis with acute bowel obstruction	14.6	$29 per unit	423.00
44120	Enterectomy - small bowel resection	17.6	$29 per unit	510.40
44140	Colectomy - partial	18.5	$29 per unit	533.60
44320	Colostomy - temporary/ permanent	11.5	$29 per unit	333.50
44950	Appendectomy	10.0	$29 per unit	290.00
47600	Cholecystectomy	17.0	$29 per unit	493.00
47605	Cholecystectomy with cholangiogram	18.0	$29 per unit	522.00
47610	Cholecystectomy with common duct expl.	20.0	$29 per unit	580.00
48100	Biopsy - pancreas	15.0	$29 per unit	435.00
49000	Exploratory laparotomy	10.0	$29 per unit	290.00
49500	Hernia - under 5 years	8.0	$29 per unit	232.00
49505	Hernia - over 5 years	8.5	$29 per unit	246.50
60220	Total thyroid lobectomy (unilateral)	14.0	$29 per unit	406.00
60240	Thyroidectomy - total	19.0	$29 per unit	551.00
64721	Decompression - median nerve	8.4	$29 per unit	243.60

Attachment B

Amendments of 1983" (P.L. 98-21), secs. 2350(a), (b)(1) and (2), (c) and 2354(b)(37) and (38) of the "Medicare and Medicaid Budget Reconciliation Amendments of 1984" (P.L. 98-369).

[¶ 17,097]

PENALTIES

[42 U.S.C. § 1395nn]

Sec. 1877. (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to—

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title, and

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(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, or home health agency (as those terms are defined in section 1861), shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever accepts assignments described in section 1842(b)(3)(B)(ii) or agrees to be a participating physician or supplier under section 1842(h)(1) and knowingly, willfully, and repeatedly violates the term of such assignments or agreements, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $2,000 or imprisoned for not more than six months, or both.

1984 Amendments:

Section 2306(f)(2) of the "Medicare and Medicaid Budget Reconciliation Amendments of 1984," effective July 18, 1984, made the following changes in subsection (d):

Added "or agrees to be a participating physician or supplier under section 1842(h)(1)" after "1842(b)(3)(B)(ii)".

Substituted "or agreement" for "specified in subclause (I) of such section".

1980 Amendments:

Section 917 of the "Medicare and Medicaid Amendments of 1980," effective December 5, 1980, added "knowingly and willfully" after "Whoever" in paragraphs (b)(1) and (b)(2).

1977 Amendments:

Prior to amendment by section 4(a) of the "Medicare-Medicaid Anti-Fraud and Abuse Amendments," effective with respect to acts occurring and statements or representations made after October 24, 1977, section 1877 read as follows:

"Sec. 1877. PENALTIES.—(a) Whoever—

"(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under this title,

"(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit or payment,

"(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

"(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

"(b) Whoever furnishes items or services to an individual for which payment is or may be made under this title and who solicits, offers, or receives any—

"(1) kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or

"(2) rebate of any fee or charge for referring any such individual to another person for the furnishing of such items or services,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

"(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, or home health agency (as those terms are defined in section 1861), shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $2,000 or imprisoned for not more than 6 months, or both."

1972 Amendments:

Sec. 1877 was added by section 242(b) of the SS Amendments of 1972, not applicable to any acts, statements, or representations made or committed prior to October 30, 1972

Section 278(b)(8) of the SS Amendments of 1972, effective October 30, 1972, substituted "skilled nursing facility" for "extended care facility" in subsection (c)

Attachment C

ROBERT W. GEIST, M.D.

658 DOCTORS PROFESSIONAL BUILDING
280 NORTH SMITH AVENUE
ST. PAUL, MINNESOTA 55102

PRACTICE LIMITED TO UROLOGY

TELEPHONE (612) 227-9518

I would recommend the following change in the language for proposed ammendment paragraph (p)(2) in Section 147.091, Subdivision 1.

> (p)(2) - "dividing fees with another physician or professional corporation, unless the division is pursuant to a billing arrangement by which each provider is paid for the services provided by each. A billing arrangement may assign uniform percentage values to the provision of facilities."

This change in the language employs a fair rental principle in order to make it clear that fee-splitting for the referral of patients is improper but that division of fees proportional to services delivered is strictly adhered to in contracts between independant contractors. This proposed change in the language would make a broad prohibition against improper fee-splitting while making evident the limits which are otherwise ambiguous in the law. Precise delineation of the limits would avoid improper fee-splitting and would prevent improper actions which are unanticipated at this time.

No. _

OFFERED ONLY TO T

NASHVILLE IMAGING CENTER, L.P.

A DELAWARE LIMITED PARTNERSHIP

311 22nd Avenue North
Nashville, Tennessee 37203
615-329-4363

CONFIDENTIAL OFFERING MEMORANDUM

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297 LIMITED PARTNERSHIP UNITS

Minimum Investment - Two Units

Price Per Unit $1,000
(Cash)

	Price to Offerees	Proceeds to Partnership*
Per Unit	$ 1,000	$ 1,000
TOTAL	$297,000	$297,000

*LESS AGGREGATE EXPENSES OF THE OFFERING, INCLUDING LEGAL, ACCOUNTING, ADMINISTRATIVE, AND MISCELLANEOUS EXPENSES ANTICIPATED TO BE APPROXIMATELY $150,000.

THIS OFFERING MEMORANDUM CONTAINS ESSENTIAL INFORMATION ABOUT THE ISSUER, ITS GENERAL PARTNER, AND THE SECURITIES BEING OFFERED. PERSONS ARE ADVISED TO READ THIS OFFERING MEMORANDUM CAREFULLY PRIOR TO MAKING ANY DECISION TO PURCHASE THESE SECURITIES.

April 6, 1988

I. IMPORTANT CONSIDERATIONS

THE UNITS IN THIS PARTNERSHIP ARE SECURITIES AND HAVE NOT BEEN APPROVED OR DISAPPROVED BY THE SECURITIES AND EXCHANGE COMMISSION OR THE TENNESSEE COMMISSIONER OF COMMERCE AND INSURANCE NOR HAS EITHER PASSED UPON THE ACCURACY OR ADEQUACY OF THIS MEMORANDUM. ANY REPRESENTATION TO THE CONTRARY IS UNLAWFUL.

THIS MEMORANDUM DOES NOT CONSTITUTE AN OFFER TO SELL NOR THE SOLICITATION OF AN OFFER TO BUY UNITS, NOR SHALL THERE BE ANY SALE OF SUCH UNITS IN ANY STATE OTHER THAN THE STATE OF TENNESSEE.

PROSPECTIVE INVESTORS ARE NOT TO CONSTRUE THE CONTENTS OF THIS MEMORANDUM AS INVESTMENT, LEGAL, OR TAX ADVICE. EACH INVESTOR SHOULD CONSULT HIS OR HER OWN COUNSEL AND ACCOUNTANT AS TO LEGAL, TAX, AND RELATED MATTERS CONCERNING AN INVESTMENT IN THE UNITS.

THIS INVESTMENT INVOLVES CERTAIN RISKS. IT ALSO INVOLVES TRANSACTIONS WHICH WILL RESULT IN SUBSTANTIAL PAYMENTS AND PROFITS TO THE GENERAL PARTNER AND ITS AFFILIATES AND INVOLVES CONFLICTS OF INTEREST FOR THE GENERAL PARTNER. INVESTORS WILL BE REQUIRED TO REPRESENT THAT THEY ARE FAMILIAR WITH AND UNDERSTAND THE TERMS OF THIS OFFERING.

THE UNITS WILL NOT BE REGISTERED UNDER THE FEDERAL SECURITIES ACT OF 1933, AS AMENDED, IN RELIANCE ON THE EXEMPTIONS FROM REGISTRATION PROVIDED BY SECTIONS 3(a)(11) AND 4(2) OF THE ACT, AND/OR RULE 147 AND REGULATION D THEREUNDER. THE UNITS WILL NOT BE REGISTERED UNDER THE TENNESSEE SECURITIES ACT IN RELIANCE ON THE EXEMPTION FROM REGISTRATION PROVIDED BY THE TENNESSEE UNIFORM LIMITED OFFERING EXEMPTION, RULE 0780-4-2, UNDER SUCH ACT.

THERE WILL BE NO PUBLIC MARKET FOR THE UNITS AND TRANSFERABILITY OF THE UNITS WILL BE LIMITED. AS A PURCHASER OF SECURITIES IN A PRIVATE PLACEMENT, EACH INVESTOR SHOULD PROCEED ON THE ASSUMPTION THAT HE OR SHE MUST BEAR THE ECONOMIC RISK OF THE INVESTMENT FOR AN INDEFINITE PERIOD.

THE DELIVERY OF THIS MEMORANDUM DOES NOT IMPLY THAT THE INFORMATION CONTAINED HEREIN IS CORRECT AS OF ANY TIME SUBSEQUENT TO THE DATE HEREOF.

NO OFFERING LITERATURE OR ADVERTISING IN ANY FORM SHALL BE EMPLOYED IN THE OFFERING OF UNITS EXCEPT FOR THIS MEMORANDUM OR STATEMENTS CONTAINED HEREIN. NO PERSON HAS BEEN AUTHORIZED TO MAKE REPRESENTATIONS OR DISTRIBUTE ANY OFFERING LITERATURE WITH RESPECT TO THE UNITS EXCEPT THE INFORMATION CONTAINED HEREIN.

EACH OFFEREE SHOULD THOROUGHLY REVIEW THE TEXT OF THIS MEMORANDUM INCLUDING EACH APPENDIX BEFORE DECIDING TO ACQUIRE ANY UNITS. THIS MEMORANDUM HAS BEEN PREPARED ON THE BASIS OF INFORMATION PROVIDED BY THE GENERAL PARTNER AND OTHER PERSONS DEEMED RELIABLE BY IT.

THIS MEMORANDUM CONTAINS WHAT THE GENERAL PARTNER BELIEVES TO BE A FAIR SUMMARY OF THE MATERIAL TERMS OF THE DOCUMENTS REFERRED TO HEREIN AND DOES NOT, TO THE BEST KNOWLEDGE OF THE GENERAL PARTNER, CONTAIN ANY UNTRUE STATEMENT OF A MATERIAL FACT OR OMIT TO STATE A MATERIAL FACT NECESSARY TO MAKE THE STATEMENTS HEREIN NOT MISLEADING OR FAIL TO STATE ANY MATERIAL FACT REQUIRED TO BE STATED HEREIN.

PROSPECTIVE PURCHASERS AND PURCHASER REPRESENTATIVES ARE ENCOURAGED TO REVIEW ANY DOCUMENTS, ASK SUCH QUESTIONS OF THE GENERAL PARTNER, AND OBTAIN FROM THE GENERAL PARTNER SUCH ADDITIONAL INFORMATION AS THEY MAY DEEM NECESSARY TO EVALUATE AND UNDERSTAND THE MERITS AND RISKS RELATED TO THE PARTNERSHIP, THE CENTER, AND THE TERMS OF THIS OFFERING.

The General Partner will be pleased to provide such information concerning the terms and conditions of the Offering, the Partnership, and any other relevant matters (including, but not limited to, additional information to verify the accuracy of the information set forth in this Memorandum), to the extent the General Partner possesses such information or can acquire it without unreasonable effort or expense. Any additional information may be obtained from the General Partner by making an inquiry to the following person:

Charles L. Robinette, Jr., M.D.
Quantum Corporation
311 22nd Avenue North
Nashville, Tennessee 37203

NASHVILLE IMAGING CENTER, L.P.

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Appendix A	Partnership Initial Balance Sheet
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II. SUMMARY

THE FOLLOWING SECTION OF THIS OFFERING MEMORANDUM IS ONLY A SUMMARY OF CERTAIN HIGHLIGHTS OF THIS OFFERING. THIS SUMMARY IS QUALIFIED IN ITS ENTIRETY BY THE DETAILED INFORMATION AND APPENDICES CONTAINED IN THIS ENTIRE OFFERING MEMORANDUM. (Please see the section marked "GLOSSARY" for a definition of the terms used in this Offering Memorandum.)

THE PARTNERSHIP: NASHVILLE IMAGING CENTER, L.P. ("Partnership"), is a Limited Partnership which will be formed under the Delaware Revised Uniform Limited Partnership Act, Sections 17-101 et seq. of the Delaware Code Annotated, as amended from time to time. Quantum Corporation, a Tennessee professional S corporation, will be the General Partner of the Partnership (the "General Partner"). The principal place of business of the Partnership will be 311 22nd Avenue North, Nashville, Tennessee 37203. The telephone number will be 615-329-4363. The Partnership will continue until the earlier of: (1) 20 years after the Certificate of Limited Partnership is filed with the Secretary of State of Delaware; or (2) it is dissolved as provided in the Limited Partnership Agreement.

PARTNERSHIP'S OBJECTIVES: The Partnership is being formed to lease and operate a Magnetic Resonance Imaging ("MR") system, a Computer Assisted Tomography ("CT") scanner, and related equipment for the purpose of providing MR and CT outpatient diagnostic imaging services to the community. The Partnership will provide to physicians and their patients all aspects of an MR and CT outpatient diagnostic imaging service for which a license to practice medicine is not required (the "Project").

Services rendered in conjunction with the Project constituting the practice of medicine will be provided by individual physicians or their professional corporations licensed to practice in the State of Tennessee. For purposes of this Offering Memorandum ("Memorandum") such physicians are hereafter referred to as "Radiologists". From an investment standpoint, the objective of the Partnership is to provide investors current cash distributions. There is no intent to provide tax shelter or long-term capital gains to the investors.

THE OFFERING: The Partnership in this Offering is seeking to raise a total of $297,000 from the Limited Partners. The Partnership intends to raise this amount by selling 297 Limited Partnership Units ("Units") in the Partnership. The price of each Unit is $1,000 in cash. The Offering price has been determined arbitrarily by the General Partner. A minimum purchase of two Units is required. However, the General Partner, in its sole discretion, may elect to modify this requirement.

The General Partner intends to terminate this Offering on May 17, 1988. However, the Offering period may be extended to July 18, 1988 or such other earlier date as the General Partner determines, in its sole discretion. An escrow account has been opened at the Third

National Bank where all monies received will be deposited and held until the close of the Offering. If all 297 Units are not sold, the Offering will be terminated and all amounts tendered by subscribers will be returned without interest.

THE MANAGEMENT: The Partnership will be managed by its General Partner which will make all management decisions for the Partnership. The General Partner will not receive a management fee for managing the Project and overseeing the day-to-day operations of Nashville Imaging Center, L.P. (the "Center"). The General Partner will be reimbursed for all organizational and out-of-pocket expenses incurred in managing the business and affairs of the Partnership. A detailed description of the General Partner, including a discussion of its officers and directors, is contained in the "MANAGEMENT" section of this Memorandum.

ALLOCATION OF PROFITS AND LOSSES: Profits and losses of the Partnership shall be allocated in a proportionate manner based upon the respective percentages of ownership in the Partnership by each of the Partners as described in "ALLOCATION OF PROFITS AND LOSSES".

DISTRIBUTIONS OF CASH: After a reasonable reserve for the conduct of the Partnership business has been retained, cash from operations will be distributed proportionately to the General Partner and the Limited Partners on an "as available" basis in the manner described in the "CASH DISTRIBUTION TO PARTNERS" section of the Memorandum. Upon dissolution of the Partnership, any cash available will be used first to pay creditors, then to establish a reserve for any contingent creditors or liabilities, then distributed to the Partners, first as a repayment of any loans which they have made to the Partnership, and then in a distribution of an amount equal to their respective capital accounts with the remainder to be distributed proportionately based upon the respective capital accounts of the Partners.

FINANCIAL FORECASTS: This Memorandum contains certain Financial Forecasts ("Forecasts"). These Forecasts have been prepared in consultation with the General Partner and relate to the anticipated operation of the Partnership based upon the facts available to the General Partner as of the date of this Memorandum. These Forecasts are set forth as Appendix B to this Memorandum and should be carefully reviewed with particular attention to the assumptions upon which they are based.

These assumptions are set forth as notes to the Forecasts and are an integral part of the Forecasts. As in any business transaction, it must be noted that the Forecasts are based, in part, upon facts which are subject to change, or circumstances which are not ascertainable by the General Partner at this time or are beyond the General Partner's control.

NO ASSURANCE CAN BE GIVEN THAT THE ASSUMPTIONS ON WHICH THE FORECASTS ARE BASED WILL PROVE ACCURATE, OR THAT THE RESULTS REFLECTED IN THE FORECASTS WILL BE ACHIEVED. SOME ASSUMPTIONS ADOPTED BY THE GENERAL PARTNER IN PREPARING THE FORECASTS INEVITABLY WILL NOT MATERIALIZE

AND UNANTICIPATED EVENTS AND CIRCUMSTANCES MAY OCCUR; THEREFORE, THE ACTUAL RESULTS ACHIEVED DURING THE FORECAST PERIOD WILL VARY FROM THE FORECASTS AND THE VARIATIONS MAY BE MATERIAL.

USE OF PROCEEDS: The proceeds of this Offering will be used to provide initial working capital for the Partnership. Please refer to the section of this Memorandum marked "USE OF PROCEEDS" for a more detailed analysis.

RISK FACTORS: An investment in the Partnership is subject to a high degree of risk. A discussion of the significant risk factors involved in making an investment in this Partnership is presented in the "RISK FACTORS" section of this Memorandum. The "RISK FACTORS" section of this Memorandum should be reviewed thoroughly by potential investors.

ADDITIONAL INFORMATION: The remainder of this Memorandum contains substantial additional information about the Partnership, its business and financial condition and certain risk factors associated with this Offering. The remainder of this Memorandum should be thoroughly and carefully reviewed prior to any investment in the Partnership. Additional information is also available from the General Partner upon request. The General Partner, its officers and directors are available to answer any questions that potential investors may have. Also, all agreements, contracts, leases, etc., are available for review upon request.

III. RISK FACTORS

Any purchase of the Units is highly speculative and involves the risk of loss of a purchaser's entire investment. The purchase of the Units offered hereby involves various risk factors. In addition to the general investment risks described throughout this Memorandum, including but not limited to, those set forth in the section entitled "CONFLICTS OF INTEREST" and the possible adverse tax consequences associated with an investment in the Units as described in the section entitled "FEDERAL INCOME TAX ASPECTS", prospective purchasers of Units should consider the following potential risks.

It should be recognized that the risk factors set forth below are those issues which, at the date of this Memorandum, are considered by the General Partner most likely to be significant. Prospective purchasers of Units should realize, however, that factors other than those set forth below may ultimately affect the investment offered pursuant to this Memorandum.

A. No Operating History

The Partnership is being organized in connection with this Offering and has no prior history of operations and earnings. The Project is being initiated with the proceeds of the Offering. Neither the General Partner nor the Partnership have any prior history of managing an MR or a CT outpatient diagnostic imaging project and the activities proposed to be undertaken by the Partnership will be the first undertaking by either the General Partner or the Partnership.

B. Management and Hiring

The General Partner has no business experience in operating an MR or a CT outpatient diagnostic imaging service. The Medical Director of the Project will be Charles L. Robinette, Jr., M.D. The General Partner will manage the day-to-day operations of the Center. There can be no assurance that the General Partner, Dr. Robinette, or anyone else the General Partner may hire will perform satisfactorily.

C. Competition

Other persons and entities in the geographical area of the Center are engaged in, or may become engaged in, providing the type of MR and CT outpatient diagnostic imaging management services proposed by the Partnership, many of which may have greater financial resources, personnel, and experience than the Partnership. Moreover, because of the nature of MR and CT outpatient diagnostic imaging services, persons and entities outside the general geographic area of the Center may also compete with the Partnership. Many of such entities may have much greater financial resources, personnel, and experience than the Partnership.

D. Obsolescence

Medical technology is in a continuing state of change, with new technologies being introduced and old techniques becoming obsolete. This is true especially in the area of MR and CT diagnostic imaging procedures and equipment. There can be no assurance that the MR or CT equipment planned to be used by the Partnership will not be rendered obsolete by advances in medical technology, or that the Partnership will be able to obtain the use of additional MR and/or CT equipment necessary to remain competitive should the equipment become obsolete. Furthermore, there can be no assurance that the Radiologists contracting with the Partnership will be or will remain technically proficient and current with the changing technology of MR and CT diagnostic imaging procedures.

E. Governmental Regulation; Third-Party Reimbursement

The General Partner submitted and was granted an exemption from Certificate of Need ("CON") requirements by the Tennessee Health Facilities Commission.

Federal and state regulations govern the licensing of the medical and technical staff at the Center and, in addition, govern which procedures are reimbursable under Medicare and Medicaid and at what rates.

There are currently no federal facility licensing requirements or regulations governing the business of the Partnership, except for laws relating to reimbursement under Medicare and Medicaid. There can, however, be no assurance that the State of Tennessee will not, at a future date, choose to regulate entities such as the Partnership or some of their activities. Additionally, there can be no assurance that Medicare and Medicaid reimbursement procedures and rates will not

change in such a manner as to have materially adverse impact on the Project's revenues and the realization of the Forecasts. Nor can there be any assurance that other non-governmental, third-party reimbursement rates and allowable procedures will not change in a manner ultimately adverse to the Partnership.

F. Restrictions on Transfer of the Units

Purchase of Units should be considered a long-term investment. Transfer of the Units is subject to significant restrictions contained in the Limited Partnership Agreement (See Summary of Limited Partnership Agreement and Appendix C, Section X). Moreover, the Units will not be registered under the Securities Act of 1933, as amended (the "Act") by reason of specific exemptions for intrastate offerings under Section 3(a)(11) of such Act, and for private placements under Section 4(2) of the Act and Rule 147 thereunder and Regulation D thereunder. Furthermore, the Units will not be qualified under the Tennessee Securities Act, but will be issued in reliance on the Tennessee Uniform Limited Offering Exemption, Rule 0780-4-2-.04, under such Act. Moreover, each Limited Partner will be required to represent in writing that he or she will not transfer his or her Units except under certain circumstances. Sales or other transfers of the Units may be made only in compliance with the Act, applicable state securities laws and the limitations set forth in the Limited Partnership Agreement.

In the event that all conditions to a transfer have been satisfied, a Limited Partner may nevertheless be unable to dispose of his or her Units, since it is unlikely that any public market will exist for the Units. Consequently, any holder of Units may be unable to liquidate an investment in the Units even though his or her personal financial circumstances would dictate such a liquidation. The Units probably will not be readily acceptable as collateral for loans. Furthermore, should an investor dispose of Units, he or she would realize taxable income at least equal to the amount by which the investor's pro rata share (for tax purposes) of any liabilities of the Partnership plus the amount of any other consideration received upon such disposition, exceeds his or her tax basis in the Units. It is possible that the Limited Partner may not receive sufficient cash to pay the taxes upon such income. (See "FEDERAL INCOME TAX ASPECTS".)

G. Limitation of Participation in Management

The management of the business and affairs of the Partnership will be vested exclusively in the General Partner. Under the Limited Partnership Agreement, Limited Partners have no participation in the management of the Partnership and have no right to take part in the control of the Partnership business. The Limited Partners have the rights given to them under the Limited Partnership Agreement, which rights are deemed to be rights affecting the basic structure of the Partnership and not the control of its business. Among the rights given to the Limited Partners is a right to remove the General Partner, but only by a vote of 90% of the Units. The Limited Partnership Agreement gives the General Partner the right to withdraw as General Partner after two years from the date of organization of the Partnership.

H. Ownership of Limited Partnership Interests by Affiliates of General Partner

Under the Limited Partnership Agreement, the General Partner and its affiliates may also acquire Units on the same terms as a Limited Partner. As a result, it is possible that the General Partner or its affiliates will own a substantial portion of the Units and have a substantial voice in any vote of the Limited Partners regarding the Limited Partnership Agreement. Their vote could effectively prevent their removal as General Partner.

I. Practice of Medicine, Rebate, Referral, and Professional Ethics Considerations

Unauthorized Practice of Medicine. Tennessee law prohibits a non-physician entity (like the Partnership) from practicing medicine, or from controlling physicians or a physician entity in the practice of medicine. This law is thus said to prohibit the "corporate practice of medicine." Although this law has existed for many years, there continues to be uncertainty about its proper interpretation. Numerous factors other than the compensation arrangement may influence the legality of a relationship under said law. These include, the status of the non-physician entity as a for-profit or non-profit corporation, the place of the non-physician entity in the traditional health care delivery system, and the availability of the services of the joint venture enterprises to the general public. However, the authorities do agree that the acceptability of an arrangement under said law does not turn on any single factor, whether it be the method of compensation or otherwise. Rather it turns on the overall relationship between the parties. If the overall relationship does not place the non-physician entity in a position of control over the medical decisions of the practitioners (here, the Radiologists), then the arrangement should not violate Tennessee law.

If such issue were raised, the Partnership could argue that under the anticipated arrangement, the Partnership will have no right to control the medical decisions of the Radiologists. The Partnership will be limited to supplying non-medical personnel, supplies, the use of equipment, and to managing the Project. Individual physicians will treat patients on their own and will collect and retain the entire professional fee for their services.

Medicare Fraud and Abuse Regulations. Federal statute requirements 42 U.S.C. Secs. 1320a-7b and 1396h(b), impose criminal penalties upon persons who provide or receive kickbacks, bribes or rebates in connection with the Medicare program. The anti-fraud and abuse rules prohibit providers and others from soliciting, offering, receiving or paying directly or indirectly any remuneration in return for making a referral for a Medicare-covered service or item or ordering any covered service or item. Violations of these rules may be punishable by a fine of up to $25,000 or imprisonment for up to five years, or both.

The interpretation and extent of enforcement of the criminal sanctions for Fraud and Abuse have not yet been completely settled although recently enacted legislation (Public Law 100-93) requires the Department of Health and Human Services to promulgate regulations during the next two years to delineate the programs which do not violate the Fraud and Abuse Proscription. This legislation also empowers the Department to exclude from the reimbursement programs providers and suppliers who engage in kickbacks regardless of whether they are convicted under the statute.

The Limited Partners are to receive cash distributions based upon the profits, if any, of the Partnership earned through the provision of services to patients referred to it by physicians, some of whom will be Limited Partners. The Limited Partners therefore may receive a greater amount of distributions if physicians refer a greater number of procedures to the Partnership. Individual investors share in the Partnership's profits only in proportion to their respective investments in the Partnership and not in accordance with the number of referrals each makes. Arguably, therefore, the physician investors' sharing of Partnership profits would not be a prohibited kickback of rebate. The Third Circuit United States Court of Appeals has recently held that the fraud and abuse rules are violated if one purpose (as opposed to a primary or sole purpose) of a payment to a provider is to induce referrals. U.S. v. Greber, 760 Fed. 2d 68(1985). The Greber case involved the payment of fees for alleged professional services. Although the Greber holding (i.e., the one purpose test) casts an extremely wide net, its application to the present facts is not clear.

Although as above stated, the present arrangement, which involves the allocation of profits on the basis of ownership interests held, arguably is not objectionable on these grounds, it is clear that as the number of referrals increase, revenues and, potentially, profits will increase. It is not inconceivable therefore that the Partnership's activities may be held to violate the anti-fraud and abuse rules and subject the Partnership and the Partners to criminal sanctions.

The Health Care Finance Administration (agency charged with enforcing these rules) has announced a policy of scrutinizing and evaluating joint ventures among health care providers under the fraud and abuse rules, and this area of the law is in a state of rapid development and change. Because of the changing state of the law and the lack of clear authority, it is not possible to give a more precise analysis of the application of the fraud and abuse provisions to the Partnership. The General Partner believes that the risk that this Partnership is conducting its business in a manner which violates Tennessee law, the Medicare-Medicaid laws, or professional medical ethics is not significant.

Professional Ethics. The Judicial Council of the American Medical Association (the "AMA") has issued an opinion which states that physicians have an ethical obligation to disclose to their patients their financial interest in any health care facility to which they refer such patients prior to utilization of any such health care facility by such patients. AMA, Current Opinions of the Judicial

Council, Sec. 4.05. Further, this opinion provides that any conflict must be resolved for the patients' benefit. Each Limited Partner must exercise his or her own ethical discretion and consult his or her own professional advisors in determining whether and in what form such disclosures should be made.

Potential Prohibition of Referrals. From time to time, legislation may be introduced in the Tennessee Assembly which would prohibit physicians from referring patients to any health care facility or other health care provider in which the physician has any beneficial interest. Should such legislation be enacted, Limited Partners who refer their patients to the Project will be prohibited from so doing. Violations of this provision, if enacted, could bring criminal penalties and/or the suspension or revocation of a physician's license. No predictions can be provided as to the likelihood of the eventual passage of any such legislation. In such an event, Section 10.7 of the Limited Partnership Agreement provides that the Partnership may repurchase the Units of the Limited Partners.

J. Possible Insufficiency of Revenues Generated by the Project to Meet Partnership Obligations

There can be no assurance that the operating expenses of the Project will not exceed, or that the revenues generated by the Partnership will equal, those shown in the Forecasts. In either such event, the Partnership could have insufficient cash flow to pay its operating expenses. In such event, it would be extremely unlikely that the Partnership could continue to operate.

The General Partner has no right to assess the Limited Partners; moreover, the General Partner and its affiliates have no obligation to provide funds to the Partnership, through loans or otherwise, even if the failure to do so could result in a default under the Partnership's obligations. The Partnership's revenue is directly related to referral of patients to the Center and the utilization of the services of the Partnership by the physicians. Utilization is affected by many factors including competition (see "RISK FACTORS -- Competition"). A decrease in utilization of the Center's services will cause a decrease in Partnership revenue. This decrease in Partnership revenue could in turn, cause the Partnership to default on its obligations and foreclosure on the Partnership assets and could cause additional adverse tax and other consequences to the Partnership and the Limited Partners.

K. No Certainty of Distributions

There is no assurance there will be any cash distributions from the Partnership, or if there are, of the time at which such distributions will be made. Cash available for distribution if any shall at all times be subject to the required payment of Partnership expenses and the maintenance of reserves deemed appropriate by the General Partner.

L. Return on Investment

No assurance can be given that a Limited Partner will realize a substantial return on his or her investment, or any return at all, or that he or she will not lose the entire investment. For this reason, each prospective investor should read this Memorandum and all Appendices carefully and should consult with his or her own personal attorney, accountant, and/or business advisor prior to making any investment decision.

M. Financial Forecasts

The Financial Forecasts (Appendix B) and the Partnership Initial Balance Sheet (Appendix A) were prepared, in consultation with the General Partner, by The Cooperative, of Del Mar, California, approved by the General Partner, and are based on assumptions and hypotheses made by the General Partner and The Cooperative regarding future events. Forecasts are prospective financial statements that present, to the best of the responsible party's knowledge and belief, an entity's expected financial position, results of operations, and changes in financial position. The American Institute of Certified Public Accountants further defines financial forecasts as based on assumptions reflecting conditions that the responsible party (in this case, the General Partner) expects to exist and the course of action it expects to take. Nonetheless, there is no assurance that actual events will correspond with these assumptions. Actual results for any period may or may not approximate such statements.

N. Tax Shelter

No tax losses will be available from the Partnership if operations are successful. The Partnership objectives do not plan to create any tax shelter.

O. Federal Income Tax Considerations

When considering an investment in the Units, each Limited Partner and his or her advisors and offeree representatives, if any, should consider the consequences of the income tax risks described in "FEDERAL INCOME TAX ASPECTS". THERE CAN BE NO ASSURANCE THAT EXISTING TAX LAWS AND REGULATIONS WILL NOT BE AMENDED IN A WAY THAT ADVERSELY AFFECTS THE TAX TREATMENT AFFORDED THE PARTNERSHIP AND/OR THE PARTNERS. In fact, recently adopted tax legislation will have a significant effect on the Partners (see "Recent Changes to Tax Law").

P. Financing

Negotiations for the necessary financing are underway but have not been finalized. While there is no guaranty that the necessary financing will be obtained, the General Partner believes the negotiations will result in the Partnership receiving the required financing.

IV. SUITABILITY STANDARDS - WHO MAY INVEST

The Partnership is offering the Units in reliance upon certain exemptions from the registration and qualification requirements of federal and state securities laws. The Partnership has established certain standards that must be met by persons who wish to purchase Units. The suitability standards are summarized below, and all of the standards, representations and warranties are set forth in detail in the Subscription Agreement (Appendix D).

AS A RESULT OF THE RISKS ASSOCIATED WITH THIS OFFERING, AN INVESTMENT IN THE UNITS SHOULD BE CONSIDERED ONLY BY INVESTORS (i) WHO HAVE SUBSTANTIAL MEANS SO THAT THEY CAN AFFORD AN ILLIQUID LONG-TERM INVESTMENT AND CAN BEAR A COMPLETE LOSS THEREOF; AND (ii) WHO HAVE THE SOPHISTICATION AND EXPERIENCE NECESSARY TO EVALUATE THIS INVESTMENT.

Those persons who wish to invest must meet all applicable criteria explained below. In order for a corporation or partnership to qualify to invest in the Offering, each equity owner must satisfy one of the financial requirement tests outlined below and must have, either alone or together with a purchaser representative, the requisite business knowledge and financial sophistication described below.

All Purchasers -- Tennessee Residents, Business Knowledge and Investment Sophistication

The Units offered hereby are suitable only for those investors who: (i) can afford to bear the economic risk of their investment for an indefinite period; (ii) have no need for liquidity in this investment; (iii) have sufficient net worth to sustain a loss of their entire investment; and (iv) maintain their principal residence in Tennessee. In connection with the standards of sufficient net worth, each investor is required to represent that he or she has (a) a net worth of at least $50,000 or (b) a net worth of $30,000 and a personal income of at least $30,000 in each of the previous two years. If an individual subscribes for several Units, he or she may be required to represent that he or she has a greater net worth than mentioned above. Each investor will also be required to represent that: (i) the investor is acquiring the Units being purchased for his or her own account for investment and not with a view for resale or distribution; (ii) he or she is aware that the right to transfer the Units is restricted by applicable securities laws, the Limited Partnership Agreement and the absence of a market for the Units; and (iii) the investor, together with his or her offeree representative, if any, possess such knowledge and experience in financial and business matters as to be capable of evaluating the merits and risks of this investment. The Partnership may sell Units to no more than 35 prospective investors who meet the general conditions set forth above but who do not qualify as Accredited Investors.

Accredited Investors -- Financial Requirements

The Partnership may sell Units to any number of investors who, in addition to meeting the general standards of business knowledge and investment sophistication outlined above and required of all purchasers, are also "accredited investors" as that term is defined in Rule 501(a) of Regulation D promulgated by the Securities and Exchange Commission. To be an Accredited Investor, an investor must meet one of the following standards:

(a) If the investor is an individual:

(i) The investor must have an individual income in excess of $200,000 in each of the two most recent years and must reasonably expect an income in excess of $200,000 in the current year; or

(ii) The investor must have an individual net worth, or a joint net worth with his or her spouse, at the time of sale, in excess of $1,000,000 (net worth for this purpose includes home, home furnishings, and automobiles); or

(iii) The investor's total purchase of Units must be in the amount of $150,000 or more and must not exceed 20% of the investor's net worth or joint net worth with his or her spouse, at the time of sale; or

(b) If the investor is a trust, each beneficiary of the trust is an Accredited Investor as defined in subparagraph (a) above; or

(c) The investor must otherwise satisfy the General Partner that he or she is an Accredited Investor as defined by the Securities Act and Regulation D thereunder.

Other categories of Accredited Investors are: certain institutional investors, including certain banks, whether acting in their individual or fiduciary capacities; certain insurance companies; federally registered investment companies; business development companies (as defined under the Investment Company Act of 1940); small business investment companies licensed by the Small Business Administration; organizations described in Section 501(c)(3) of the IRS Revenue Code with total assets in excess of $5,000,000, and certain affiliates of the Partnership. If an investor is purchasing as a custodian for a minor, the net worth and/or annual gross income standards will be applicable to the minor rather than to the custodian.

Other Requirements

The Subscription Agreement (Appendix D) sets forth certain other requirements. For example, investors are requested to certify that they have read this Memorandum and its Appendices carefully, and that they are purchasing Units for their own accounts and not with a view to resale or otherwise transfer. Any misrepresentation by an investor

could have a material adverse effect on the Partnership and may subject the investor to liability for any damage caused to the Partnership and to other investors.

The Offering is not being registered under the Securities Act of 1933, as amended (the "Securities Act"), in reliance upon exemption from registration provided by Sections 3(a)(11) and 4(2) of the Securities Act and/or Rule 147 and Regulation D thereunder. In addition, the Offering of Units will not be registered under the Tennessee Securities Act in reliance upon the exemption from registration provided by the Tennessee Uniform Limited Offering Exemption, Rule 0780-4-2-.04, under that Act. The suitability requirements are designed to insure that such exemptions are available. The General Partner has the right in its sole discretion to reject any subscription even if the prospective investor satisfies the described suitability tests.

V. THE OFFERING

The Partnership and the General Partner

NASHVILLE IMAGING CENTER, L.P., a Delaware Limited Partnership, is being formed as a Limited Partnership in accordance with the provisions of the Delaware Revised Uniform Limited Partnership Act, Sections 17-101 et seq. of the Delaware Code Annotated, as amended. The General Partner of the Partnership is **QUANTUM CORPORATION**, a Tennessee professional S corporation. The shareholders of Quantum Corporation are also shareholders in Radiology Consultants, Inc. ("RCI"), a Tennessee professional corporation. The address of the General Partner is 311 22nd Avenue North, Nashville, Tennessee 37203.

Limited Partner Contributions

The Limited Partners will contribute $297,000 in the form of cash through the purchase of 297 Limited Partnership Units. The cash will be used as operating capital.

Termination of the Partnership

The Partnership will commence on the date that the Certificate of Limited Partnership is recorded and shall terminate 20 years after such date unless sooner terminated in accordance with the Limited Partnership Agreement.

Compensation to General Partner and Affiliates

The General Partner and its affiliates will receive fees, profits, and compensation in connection with the operation of the Partnership as described under "COMPENSATION, FEES, AND INTEREST IN THE PARTNERSHIP".

Partnership Objectives

The Partnership is being formed to lease a Magnetic Resonance Imaging (MR) system, a Computer Assisted Tomography (CT) system, and related equipment for the purpose of providing MR and CT outpatient diagnostic

imaging services to the community. The Partnership intends to provide to investors current cash distributions. There is no intent to provide tax shelter or long-term capital gains to the investors. The Partnership will provide to physicians and their patients all aspects of an MR and CT outpatient diagnostic imaging service for which a license to practice medicine is not required. Services rendered in conjunction with the Project constituting the practice of medicine will be provided by individual physicians or their professional corporations licensed to practice medicine in Tennessee. Other diagnostic imaging modalities may be added in the future.

Allocation of Profits, Losses, and Distributions Among Partners

The purchase of a Unit allows the purchaser to share in the profits, losses and distributions of the Project in accordance with Section VIII of the Limited Partnership Agreement (Appendix C). See "ALLOCATION OF PROFITS AND LOSSES" for a detailed description of the allocations of Partnership profits and losses, and "CASH DISTRIBUTIONS TO PARTNERS" for a detailed description of allocations of distributable net profits of the Partnership.

VI. PARTNERSHIP BUSINESS

The Partnership intends to lease from a yet-to-be determined equipment manufacturer a high-field strength (1.5 Tesla) MR system and a high-quality CT system for approximately $2,900,000 including tax. Leasehold improvements, furniture, and fixtures will be leased or financed from a local source. The General Partner expects that all the aforementioned will be leased at an amount that should not exceed $60,000 per month for 60 months.

Diagnostic Facility

The Center will be located in the Park View-Westside-Baptist area. The General Partner has purchased approximately 25,000 square feet of land and intends to build a building to house the MR and CT scanners. To fully utilize the available land, the General Partner anticipates excess building space that can be rented to non-Center tenants. The cost of the Center will be approximately $120 per square foot. The minimum space required for the Center is approximately 4,500 square feet. The additional office space will increase the total building to approximately 10,000 square feet. The expected pro rata cost of the building and land for the Center will range from $800,000 to $950,000.

The General Partner will lease a pro rata share of the building (said lease to be available for review to any prospective investor upon request) "at cost" (principal, interest, taxes, insurance, etc.) to the Partnership for an initial period of five years. The General Partner expects that the building space will be leased for approximately $8,000 per month. The Partnership will have three serial options to extend the lease for a period of five years per option at Fair Market Value.

Until construction of the fixed-unit site is completed, a Mobile MR magnet will be leased for $52,500 per month. The fixed site MR and CT is anticipated to open in October 1988.

Market

MR and CT have evolved from modalities found primarily in large medical centers to modalities that most experts believe every community should have. MR and CT are particularly suited to an outpatient setting in terms of patient utilization and reimbursement. The market area to be serviced includes Nashville and surrounding communities.

Description of MR Services

MR employs radio waves together with magnetic fields to produce images of soft tissues and internal body organs. The radio frequency and magnetic energy used in MR systems do not involve ionizing radiation and are not presently known to cause any harmful effects to the patients.

MR images are created by exposing the body to strong magnetic fields which cause the hydrogen nuclei (protons) to change their alignment. When the radio frequency pulses are induced, the normal spin of the protons can be realigned and monitored. As the protons return to their normal states, radio frequency signals are emitted and recorded. Generation and detection of these radio signals is the basis of MR.

Description of CT Services

CT scanning is based on the principle of differential X-ray absorption by tissues of varying densities. However, in CT scanning, the photographic film/phosphor detection system is replaced by electronic detector cells. This allows the transmission of data to a computer for storage, subsequent processing, and conversion to an image. CT scanning is based on the compilation of data from multiple viewing angles. The data is processed through a computer which is able to produce images of a particular organ or area of the body.

CT scanning is superior to conventional X-rays in its ability to differentiate between organs or structures that overlap. By utilizing a third dimension and producing cross-sectional slices of anatomy, CT scanning practically eliminates the problem of structure overlap and greatly improves resolution capability.

Management of the Project

The General Partner will manage the Project and will oversee the day-to-day operations at the Center. The General Partner will not receive a management fee for managing the Project.

Medical Advisory Board

A Medical Advisory Board (the "Board") consisting of four physicians will be established. The Board will consist of a radiologist and three clinicians. The Board will only be responsible for making medical recommendations to the General Partner. They will not have any control over the management of the Partnership or the Center. Each member of the Board will receive a monthly fee of $150 for serving on the Board. The Board members will be appointed by the General Partner. As of the date of this Offering, the Board has not been selected. In the case of a tie vote, the Medical Director will also vote.

Professional Component

Radiology Consultants, Inc. ("RCI"), a Tennessee professional corporation, will provide all medical services. Quantum will bill and collect for all services rendered and will distribute 20% of cash collections to RCI for medical services rendered.

Government Regulation

The ability of the Partnership to meet its operating and financial obligations will be predicated upon the ability of the Radiologists to maintain a successful MR and CT outpatient diagnostic imaging practice. Extensive federal, state and local regulations govern certain types of medical facilities, the use of certain medical equipment, the individuals who may provide certain medical services and the equipment which is utilized in the practice of medicine. At present, no governmental regulations materially impact a physician's medical practice which would have a significant adverse effect on those practices. (See "RISK FACTORS -- Practice of Medicine, Rebate, Referral, and Professional Ethics Considerations".)

VII. USE OF PROCEEDS

The proceeds available from the Offering will be utilized in the following manner:

SOURCES:

Limited Partners' Cash Contribution	$297,000
TOTAL SOURCES	$297,000

USES:

Working Capital	$297,000
TOTAL USES	$297,000

Costs incurred in the development of the Partnership include, but are not limited to, organization, syndication, and legal costs ("Development Costs"). These Development Costs will be paid to Physician Ventures, Inc., a Tennessee corporation ("The Cooperative"), the project consultants for Nashville Imaging Center, L.P. These Development Costs will total $150,000. Said costs will initially be paid by the General Partner. After the Limited Partners receive cash distributions totaling $150,000, the General Partner will receive one-half (50%) of all cash distributions until the General Partner is reimbursed the $150,000 in advanced Development Costs.

The General Partner will also advance all marketing costs until the Limited Partners receive $150,000 in cash distributions. After the Limited Partners receive $150,000 in cash distributions, the Partnership will be responsible for paying for the marketing costs as they are incurred. After the Limited Partners receive $300,000 in cash distributions and the General Partner is reimbursed for the Development Costs, the General Partner will receive one-half (50%) of the cash distributions until they are reimbursed for all the advanced marketing costs. Thereafter, the Limited Partners will receive 99% of the cash distributions and the General Partner will receive the remaining 1%.

Reserves for Operations

The Partnership intends to establish an initial cash reserve of $200,000. Subsequently, the Partnership plans to maintain cash reserves of $200,000 for operational needs. The General Partner may alter these plans to meet the anticipated needs of the Partnership.

VIII. COMPENSATION OF THE GENERAL PARTNER AND AFFILIATES

The compensation payable to the General Partner and its affiliates is set forth below. None of the compensation arrangements with the Partnership is the result of arm's-length dealings.

Form of Compensation	Description of Amount	Dollar Amount
	OFFERING STAGE	
Organization and Development Fee	- The Cooperative will receive a fee for its consulting services to the Partnership in formulating the terms of the Partnership Agreement and the Offering; organizing the Partnership; assisting in arranging the capital financing, preparing the Financial Forecasts, coordinating development of the legal documents, and related services, etc.	$150,000

OPERATING PHASE

Management Fee -	The General Partner will not receive a management fee for managing the affairs of the Partnership or the Center.	None
Cash Distributions -	The General Partner will receive its pro rata share of net profits based on its Capital Contributions in relation to all the Partners' Capital Contributions. (See "COMPENSATION, FEES, AND INTEREST IN THE PARTNERSHIP".)	Pro rata share
Professional Fees -	For professional services, RCI will receive a monthly fee as the cash is is received.	20% of cash collections
Advisory Fee -	The members of the Medical Advisory Board will receive a monthly fee for services rendered in advising and making recommendations to the General Partner in connection with the Center.	$150 per month per member

IX. ACCESS TO INFORMATION

The discussions of, and references to, various documents in this Memorandum are summaries only and therefore not complete. As to each such document, reference should be made to the copy of such document which is either an Appendix to this Memorandum, or which will be made available to offerees on request.

Representatives of the Partnership will respond to questions from prospective purchasers or their purchaser representatives relating to the General Partner, the Project and this Offering. Such representatives will make available to any such persons, on request, any additional information (to the extent the General Partner possesses such information or can acquire it without unreasonable effort or expense) which is necessary to verify the accuracy of the information contained herein or which may otherwise be desired to make an informed investment decision. Inquiries should be directed to the General Partner at 311 22nd Avenue North, Nashville, Tennessee 37203, 615-329-4363.

X. MANAGEMENT

The General Partner

The business and affairs of the Partnership will be managed by the General Partner. The General Partner was incorporated as a Tennessee professional S corporation on January 21, 1988, for the purpose of purchasing and developing land, operating medical facilities, etc.

The shareholders of Quantum Corporation are also the Directors of Radiology Consultants, Inc., a Tennessee professional corporation. The officers and directors are listed below.

Officers and Directors

The executive officers of the General Partner are:

President - Charles T. Faulkner, M.D.
Vice President - Charles L. Robinette, Jr., M.D.
Secretary/Treasurer - Grover R. Smith, Jr., M.D.

The directors of the General Partner are:

Charles T. Faulkner, M.D., 44, was awarded a Bachelor of Arts Degree from the University of Virginia, Charlottesville. He received his Medical Degree in 1970 from the University of Virginia Medical School - Charlottesville. Dr. Faulkner is board certified by the American Board of Radiology. His hospital affiliations include: Park View Medical Center, West Side Hospital, and Tennessee Christian Medical Center. Dr. Faulkner has been employed with Radiology Consultants since 1974.

Charles L. Robinette, Jr., M.D., 44, was awarded a Bachelor of Engineering Degree from Vanderbilt University and a Masters Degree from Stanford University. He received his Medical Degree in 1978 from the Washington University School of Medicine. Dr. Robinette is board certified by the American Board of Radiology. Since 1982, he has been employed as a Staff Radiologist for Radiology Consultants. Dr. Robinette's hospital affiliations include Park View Medical Center, West Side Hosptial, and Tennessee Christian Medical Center.

Grover R. Smith, Jr., M.D., 49, was awarded a Bachelor of Science from the University of Tennessee, Knoxville. He received his Medical Degree in 1963 from the University of Tennessee College of Medicine, Memphis. Dr. Smith is board certified by the American Board of Radiology. He has been employed with Radiology Consultants since 1971. Dr. Smith's hospital affiliations include Park View Medical Center, West Side Hospital, and Tennessee Christian Medical Center.

Robert S. Francis, M.D., 43, was awarded a Bachelor of Arts Degree from Vanderbilt University. He received his Medical Degree in 1969 from Vanderbilt University. Dr. Francis is board certified by the American Board of Radiology. Since 1978, he has served as Chief of Radiology, West Side Hospital. Dr. Francis' hospital affiliations include: Park View Medical Center, West Side Hospital and Tennessee Christian Medical Center. He has been employed with Radiology Consultants since 1976.

James D. Green, M.D., 39, was awarded a Bachelor of Arts Degree from the University of Michigan, Ann Arbor. He received his Medical Degree in 1977 from the University of Illinois, Abraham Lincoln School of Medicine. Dr. Green is board certified by the American Board of Radiology. Since 1984, he has served as Chief of Radiology, Tennessee

Christian Medical Center. Dr. Green has been employed with Radiology Consultants since 1982. His hospital affiliations include: Park View Medical Center, West Side Hospital, and Tennessee Christian Medical Center.

Edward M. Priest, M.D., 39, was awarded a Bachelor of Science Degree from the University of Tennessee. He received his Medical Degree in 1974 from the University of Tennessee College of Medicine. Dr. Priest is board certified by the American Board of Internal Medicine and the American Board of Radiology. Since 1986, he has served as the Professional Director of Radiology at Park View Medical Center. Dr. Priest has been employed with Radiology Consultants since 1980.

William S. Keane, M.D., 45, was awarded a Bachelor of Arts Degree from Miami University, Oxford, Ohio. He received his Medical Degree in 1968 from Indiana University Medical School, Indianapolis. Dr. Keane is board certified by the American Board of Radiology. Since 1974, he has been employed with Radiology Consultants. Dr. Keane's hospital affiliations include: Park View Medical Center, West Side Hospital, and Tennessee Christian Medical Center.

Frank B. Glascock, M.D., 44, was awarded a Bachelors of Arts Degree from Memphis State University. He received his Medical Degree in 1967 from the University of Tennessee College of Medicine. Dr. Glascock is board certified by the American Board of Radiology. Since 1976, he has been employed as a radiologist with Radiology Consultants. Dr. Glascock's hospital affiliations include: Park View Medical Center, West Side Hospital, and Tennessee Christian Medical Center.

Burton Silbert, M.D., 54, was awarded a Bachelor of Arts Degree from the University Heights College of New York University. He received his Medical Degree in 1958 from Vanderbilt University School of Medicine. Dr. Silbert is board certified by the American Board of Radiology. His hospital affiliations include: Park View Medical Center, West Side Hospital, and Tennessee Christian Medical Center. Dr. Silbert has been employed with Radiology Consultants since 1963.

Michael J. Levitt, M.D., 36, was awarded a Bachelor of Science Degree from Emory University. He received his Medical Degree in 1977 from Emory University School of Medicine. Dr. Levitt is board certified in Diagnostic Radiology and is a diplomate of the National Board of Medical Examiners. Dr. Levitt's hospital affiliations include Park View Medical Center, West Side Hospital, and Tennessee Christian Medical Center. He has been employed with Radiology Consultants since 1982.

Project Management

The day-to-day operations of the Project will be overseen by an administrator designated by the General Partner. There is no guarantee that any such individual once engaged will perform satisfactorily in the administration of the Project. Other services in connection with the operation of the Project will be provided by employees and/or independent contractors (see "PARTNERSHIP BUSINESS -- Management of

the Project", "-- Employees, and "-- Professional Component"). The General Partner has appointed Charles L. Robinette, Jr., M.D., Vice President of the General Partner, to act as Medical Director for the Project for an indefinite period of time. Dr. Robinette will be responsible for the overall supervision of the Project. The General Partner will be responsible for the general business planning, overall management, and expansion plans, if any, for the Project.

Utilization Review

The General Partner intends to establish a mechanism for adequate utilization review of the scans performed in connection with the Project. This function will initially be performed by The General Partner. The General Partner, in its sole judgment, may enter into a contract on behalf of the Partnership with an outside utilization review organization. The utilization review function will not include any control over the medical decisions of any physician.

XI. CONFLICTS OF INTEREST

The General Partner and its officers, directors, shareholders, and employees will devote such time to the Partnership's business and affairs as it determines is necessary for the proper performance of their respective duties and may devote a substantial majority of its time to businesses other than the Partnership's.

The General Partner will manage the affairs of the Partnership in good faith, will use its best efforts to carry out the purposes of the Partnership, and will devote such time as is, in its judgment, necessary to the business of the Partnership. Under the Limited Partnership Agreement, the General Partner will not be liable to the Partnership or the Partners for any act or omission done or made in good faith and in a manner reasonably believed by it to be within the scope of the authority granted to it by the Limited Partnership Agreement, unless such General Partner is guilty of gross negligence, willful misconduct, or fraud in connection with such act or omission.

The General Partner or its affiliates may contract or otherwise deal with the Partnership to provide goods or services or for other purposes, provided (i) the compensation for such goods or services is reasonable and is paid only for goods and services actually furnished to the Partnership, and (ii) the contract or dealing is in writing and is for the sale of goods or services necessary to and reasonable for the Partnership. The determination of distributions from the Partnership is subject, among other things, to the discretion of the General Partner in establishing and maintaining reasonable reserves.

It appears that a conflict of interest may exist in that the shareholders of Quantum Corporation and RCI are the same individuals; and that RCI will provide the interpretation services. Also, The General Partner owns the land and building that the Partnership will be leasing to house the diagnostic imaging facility. However, the General Partner believes that all agreements between the General Partner and the Partnership are fair and reasonable.

XII. FIDUCIARY RESPONSIBILITY OF THE GENERAL PARTNER

The General Partner is accountable to the Partnership as a fiduciary and consequently must exercise good faith and integrity in handling Partnership affairs. Where the question has arisen, courts have held that a limited partner may institute legal action on his or her own behalf and/or on the behalf of all other similarly situated limited partners (a class action) to recover damages for a breach by a general partner of its fiduciary duty, or on behalf of the partnership (a partnership derivative action) to recover damages from third parties. In addition, (i) limited partners may have the right, subject to procedural and jurisdictional requirements, to bring partnership class actions in Federal courts to enforce their rights under the Federal securities laws, and (ii) limited partners who have suffered losses in connection with the purchase or sale of their interests may be able to recover such losses from a general partner where such losses result from a violation by the general partner of the anti-fraud provisions of the Federal securities laws. Since the foregoing summary describes a rapidly developing area of law, limited partners who believe that a breach of fiduciary duty by the general partner has occurred should consult with their own counsel.

The Limited Partnership Agreement provides that the General Partner shall not be liable in damages or otherwise to the Partnership or the Limited Partners and the Partnership shall indemnify and save harmless the General Partner from any loss or damage incurred by reason of any act or omission performed or omitted by it in good faith on behalf of the Partnership and in a manner reasonably believed by it to be within the scope of the authority granted to it by the Limited Partnership Agreement and in the best interests of the Partnership provided that (i) the General Partner was not guilty of gross negligence, willful misconduct, or any other breach of fiduciary duty with respect to such acts or omissions, and (ii) the satisfaction of any indemnification and any saving harmless shall be from and limited to Partnership assets and no Limited Partner shall have any personal liability on account thereof. (This indemnification shall include the payment of reasonable attorneys' fees and other expenses incurred in settling or defending any claims, threatened action, or finally adjudicated legal proceedings). Since the General Partner is not liable for damages or otherwise to the Partnership or the Limited Partners for errors and omissions not amounting to willful misconduct, gross negligence, or other breach of fiduciary duty, purchasers of the interests will have a more limited right of action than they would absent such a limitation in the Limited Partnership Agreement.

Insofar as indemnification for liabilities under the Act may be permitted to the General Partner, the Securities and Exchange Commission is of the opinion that such indemnification is against public policy as expressed in the Act and is therefore unenforceable. If a claim for indemnification against such liabilities (other than for expenses incurred in a successful defense) is asserted against the Partnership by the General Partner under the Limited Partnership Agreement or otherwise, the Partnership intends to submit to a court of appropriate

jurisdiction the question of whether such indemnification by it is against public policy as expressed in the Act and will be governed by the final adjudication of such issue. Any indemnification payment made to the General Partner would reduce the assets of the Partnership.

XIII. COMPENSATION, FEES, AND INTEREST IN THE PARTNERSHIP

Interest in the Partnership

The General Partner and Limited Partners will share in the annual profits and losses, distributions of cash, and capital of the Partnership in accordance with the following:

Interest in Profits and Losses. The interest of the Partners in Partnership profits and losses for federal income tax purposes are described in "ALLOCATIONS OF PROFITS AND LOSSES".

Interest in Capital. At the completion of the Offering, the General Partner will have an interest of 1% in the capital of the Partnership. Correspondingly, the Limited Partners will have an interest of 99% in the capital of Partnership.

Interest in Cash Distributions from Operations. Distributions of cash from Partnership operations shall be distributed 99% to the Limited Partners and 1% to the General Partner until the Limited Partners recover $150,000 of their original capital contributions. (See "Other Fees and Compensation" in this Section for a more detailed explanation.) All amounts allocated for distribution to the Limited Partners shall be apportioned among them pro rata based on Units held. All amounts allocated for distribution to the General Partner shall be apportioned at the same rate as the Limited Partners.

Interest in Cash Distributions upon Dissolution. Upon a dissolution of the Partnership, or upon a sale or refinancing of all or a substantial part of the assets of the Partnership, the proceeds from such sale, refinancing, or winding up shall be distributed in the following order of priority: First, to creditors of the Partnership; second, and subject to reserves held by the General Partner, for any contingent or unforeseen liabilities, to any Partners who have extended credit to, on behalf of, or for the benefit of the Partnership; third, to each Partner to the full or pro rata extent of the capital account balance of each; and finally, the excess if any to the Partners based upon the ratio of their respective capital accounts directly prior to dissolution.

Other Fees and Compensation

The Partnership will reimburse the General Partner for any expenses incurred by the General Partner in connection with the organization of the Partnership. This amount may be paid for services in connection with this Offering Memorandum, its consultations with legal counsel, and its other fees as a facilitator in connection with the organization of the Partnership. Such expenses will not exceed $150,000.

The Development Costs will not be reimbursed until the Limited Partners receive $150,000 in cash distributions. After the Limited Partners receive $150,000 in cash distributions, the General Partner will receive 50% of the cash distributions until the General Partner recovers its advanced Development Costs.

The General Partner will also advance all marketing costs until the Limited Partners receive $150,000 in cash distributions. After the Limited Partners have received $150,000 in cash distributions, the Partnership will pay for the marketing costs as they are incurred. After the Limited Partners receive $300,000 in cash distributions and the General Partner is reimbursed for the Development Costs, the General Partner will receive 50% of the cash distributions until all advanced marketing costs have been reimbursed. Thereafter, the cash distributions will be allocated 99% to the Limited Partners and 1% to the General Partner.

XIV. FEDERAL INCOME TAX ASPECTS

CAUTION: NOTHING STATED IN THE DISCUSSION WHICH FOLLOWS IS OR SHOULD BE CONSTRUED AS TAX ADVICE TO A PROSPECTIVE INVESTOR IN THE PARTNERSHIP. EACH PROSPECTIVE INVESTOR IS URGED TO SEEK HIS OR HER OWN TAX ADVICE PRIOR TO INVESTING IN THE PARTNERSHIP.

The following statements and any other statements in this Memorandum pertaining to the Federal Income Tax consequences to the Limited Partners of an investment in the Partnership, are based upon the provisions of the Internal Revenue Code of 1986, as amended (the "Code"), including the Economic Recovery Tax Act of 1981 (the "1981 Tax Act"), the Tax Equity and Fiscal Responsibility Act of 1982 (the "1982 Tax Act"), the Tax Reform Act of 1984 (the "1984 Tax Act"), the Tax Reform Act of 1986 (the "1986 Tax Act") and the Revenue Act of 1987, the existing regulations thereunder, published rulings and court decisions.

NO ASSURANCE CAN BE GIVEN THAT LEGISLATIVE OR ADMINISTRATIVE CHANGES OR COURT DECISIONS ADVERSELY AFFECTING SUCH STATEMENTS AND OPINIONS WILL NOT OCCUR. ANY SUCH CHANGES COULD BE RETROACTIVE SO AS TO APPLY TO TRANSACTIONS PRIOR TO THE EFFECTIVE DATE OF SUCH CHANGES. It is the responsibility of each Limited Partner to satisfy himself or herself as to the Federal (or any state and local) tax consequences of purchasing a Unit by obtaining advice from the Limited Partner's own tax counsel.

Tax and Legal Matters

A. Recent Changes to Tax Law

A number of provisions of the 1986 Tax Act have an adverse tax impact on investments in limited partnerships. (This description is accurate as of this date, but it should be noted that the United States Congress is constantly reviewing the tax law and the Internal Revenue Service is in the process of writing additional regulations.) Some of the more important changes relevant to this Offering are:

Reduction in Maximum Tax Rates. In 1988, the highest stated federal individual income tax rate is 28%. However, the effective tax rate will in some cases equal 33% due to certain phase-outs of tax benefits that apply over certain income ranges. The effect of this tax rate is to decrease the attractiveness of any deductions or credits generated by an investment in the Units.

Capital Gains Taxable as Ordinary Income. In 1988, the preferential tax rate applicable to net capital gains has been repealed and all net capital gains are to be taxed at the same tax rates applicable to other income. (Net capital gains is the excess of certain gains over offsetting losses.) Thus, a sale of the Partnership's property, or a sale of an interest in the Partnership may be fully taxable at the applicable individual tax rate.

Limitations on Passive Losses. The 1986 Tax Act and the Revenue Act of 1987 significantly limit a taxpayer's ability to deduct tax losses from passive activities against earned income and certain investment income. A passive activity, for this purpose, would include a Limited Partnership Interest in the Partnership. Any limited losses are to be carried forward to succeeding years.

These 1986 Tax Act changes significantly reduce any possible tax advantages from all investments that produce losses. However, if the actual Partnership results approximate the attached Forecasts, these changes will not have an adverse effect since the Forecasts reflect no net tax losses.

Limitation on the Deduction of Interest. The current deductibility of the following categories of interest has been limited:

(1) Personal Interest. Personal Interest is defined as all interest not incurred in connection with a trade or business or investment interest (other than certain interest on debt secured by the taxpayer's principal residence and a second residence);

(2) Investment Interest. Investment Interest is defined as interest paid or accrued on indebtedness incurred or continued to purchase or carry property held for investment. Interest expense within passive activities of a partnership is excluded from the Investment Interest limitations of the partners. However, Investment Interest does include the portion of any interest expense incurred or continued to purchase or carry an interest in a passive activity (such as Units in the Partnership), to the extent attributable to portfolio income of the passive activity. Furthermore, the portion of passive losses allowable as a deduction during the phase-in period must be subtracted from investment income for purposes of limiting otherwise deductible investment interest expense.

Thus, a Limited Partner's share of the Partnership's net loss may limit the deductibility of certain interest expense. Disallowed Personal Interest is permanently nondeductible, while disallowed Investment Interest is eligible for an unlimited carryforward,

subject to annual limitations in each carryforward year. The new limitations on deduction of certain interest will be subject to a phase-in period. In 1988, 40% of such interest will be currently deductible. This percentage drops to 20% and 10% for the years 1989 and 1990, respectively. After 1990, no deduction will be allowed for consumer interest.

Cost Recovery (Depreciation). The Accelerated Cost Recovery System ("ACRS") (see "Continuing Tax Law -- Depreciation") has been revised. The new system will still allow cost recovery depreciation, but over recovery periods which may be longer than those applicable under ACRS. Under the 1986 Tax Act, qualified technological equipment is to be depreciated on the straight-line method over a recovery period of five years. This applies to most property placed in service on or after January 1, 1987.

Alternative Minimum Tax. Partner taxpayers are subject to an expanded Alternative Minimum Tax applied at a 21% rate (versus 20% under previous law). Deductions from passive activities, excess accelerated depreciation on personal property, and several other items must be added back as preferences and are all subject to the Alternative Minimum Tax.

Investment Tax Credit. The 1986 Tax Act repealed the Investment Tax Credit. Therefore, no Partner may claim any amount of Investment Tax Credit.

EACH PROSPECTIVE INVESTOR SHOULD CONSULT HIS OR HER OWN TAX ADVISOR WITH RESPECT TO THE POSSIBLE IMPACT OF THE 1986 TAX REFORM ACT UPON AN INVESTMENT IN THE PARTNERSHIP.

B. Continuing Tax Law

In addition to those changes made by the 1986 Tax Act discussed above, a variety of risks under the current tax law will continue to face prospective investors.

Possible Classification of a Partnership as an Association Taxable as a Corporation. The Partnership does not intend to obtain a ruling from the Service on the tax status of the Partnership. There can be no assurance that the Service will not classify the Partnership upon audit as an association taxable as a corporation. If the Service were to take such a position and to prevail on this issue, the tax treatment reflected in the Forecasts would not be accurate and may require payment of significantly more tax by the Partners. Contesting a Service determination that the Partnership is taxable as an association may require the Limited Partners to incur substantial legal fees and other costs.

Possible Disallowance of Deductions and Allocations. While the Partnership intends to seek the advice of professional tax advisors, there can be no assurance that some of the deductions claimed by the Partnership and the allocations among Partners will not be challenged by the Service. To the extent that deductions claimed by the Partnership

or allocations among Partners are successfully challenged, the tax benefits the Limited Partners can expect to receive will be adversely affected.

Fees. The Service has indicated that it intends to scrutinize closely any deductions for management or other fees payable to a general partner or an affiliate of a general partner. Consequently, the likelihood that fees paid to a general partner or an affiliate of a general partner will be disallowed by the Service is greater than a similar fee paid to an unrelated third party pursuant to an arm's-length agreement. The Service may challenge the Partnership's treatment of all or a portion of the various fees provided for in the Partnership Agreement and discussed under "COMPENSATION, FEES, AND INTEREST IN THE PARTNERSHIP" either on the grounds that the fees are excessive, or that all or a portion of the fees should be considered payment for other services performed, or other value provided by the recipient of the fee, or that the fee should be capitalized by the Partnership.

Fees payable to the General Partner or its affiliates by the Partnership include a fee covering services in connection with the organization of the Partnership. In addition, the Partnership is to pay the organization costs and certain syndication costs. Organization costs are not deductible, but the Partnership can elect to amortize them over 60 months; syndication costs incurred by the Partnership are neither deductible nor amortizable.

Risk of Audit. The Service has announced a policy of auditing substantially more partnerships than it has in the past. An audit of any of the tax returns of the Partnership would cause the Partnership to incur additional legal and other costs and may result in adjustments to the Partnership's tax return. This, in turn, would require an adjustment to each Limited Partner's personal return. An audit of the Partnership's tax returns may also result in an audit of non-partnership items on each Limited Partner's tax return. Any audit of a Limited Partner's tax return may involve substantial legal fees and other costs to the Partner, which the Partnership has no obligation to bear.

The 1982 Tax Act established a partnership audit procedure whereby items of partnership income, gains, losses, deductions, and credits are determined at the partnership level in a unified partnership audit. In addition, the 1982 Tax Act permits the "tax matters partner" (the General Partner in the case of the Partnership) to extend the statute of limitations with respect to partnership items by agreement with the Service on behalf of the partnership without the consent of the limited partners. The General Partner will exercise reasonable judgment in doing so.

Partnership Status

The General Partner believes that the Partnership will be most likely treated as a partnership for Federal Income Tax purposes and not as an association taxable as a corporation. The tax aspects of the Offering discussed in this Memorandum are based on the assumption

that the Partnership will be so treated. However, the Partnership has not requested nor does it intend to request a ruling from the Service that the Partnership will be treated as a partnership for Federal Income Tax purposes. The belief of the General Partner is not binding upon the Service, and there is no assurance that the Service will not assert that the Partnership should be classified as an association taxable as a corporation.

The Treasury Regulations are the principal authority for classifying a limited partnership as a partnership for Federal Income Tax purposes. Treasury Regulation Section 301.7701-2(a)(1) provides that an organization will not be treated as an association taxable as a corporation unless the organization has more major corporate characteristics than non-corporate characteristics. In determining whether an organization is to be treated for tax purposes as a partnership or a corporation, the four relevant corporate characteristics are: (i) continuity of life; (ii) centralization of management; (iii) limited liability; and (iv) free transferability of interest. The Tax Court, in Larson v. Commissioner, 66 T.C. 159 (1976), acq., 1979-1 C.B. 1, held that where only two of the four above listed characteristics are found to exist, the organization will not be deemed a corporation, but instead will be classified as a partnership. Such holding is consistent with Treas. Reg. Section 301.7701-2(a)(3).

1. Continuity of Life. Treasury Regulation Section 301.7701-2(b)(1) provides that "if the death, insanity, bankruptcy, retirement, resignation, or expulsion of any member will cause a dissolution of the organization, continuity of life does not exist". The regulation specifically states that there is no continuity of life if the retirement, death, or insanity of a general partner of a limited partnership can cause a dissolution of the partnership (absent agreement among the remaining general partners or members). The Limited Partnership Agreement provides that the Partnership will dissolve no later than at a fixed time or upon the earlier occurrence of various events including the dissolution of the General Partner or the retirement, resignation, or bankruptcy of the General Partner, if that General Partner is the last remaining General Partner, unless the Limited Partners elect to continue the Partnership. Termination upon such events with election by the Limited Partners required to continue the Partnership is indicative of the absence of continuity of life under Treas. Reg. Sec. 301.7701-2(b)(1) and (b)(2). Also, under the Regulations, limited partnerships formed under statutes corresponding to the Uniform Limited Partnership Act generally lack the corporate characteristic of continuity of life (See Treasury Regulation Section 301.7701-2(b)(3)). The Service has ruled that the Delaware Revised Uniform Limited Partnership Act is a statute corresponding to the Uniform Limited Partnership Act. Rev. Rul. 84-80, 1984-1 C.B. 35. The Partnership will be a validly formed and existing Limited Partnership under the Delaware Revised Uniform Limited Partnership Act. Based upon the foregoing, the Partnership lacks the corporate characteristic of continuity of life.

2. Centralization of Management. Under the Treasury Regulations, centralization of management refers to the possession by any person (or group of persons not embracing all members) of continuing exclusive authority to make the management decisions necessary to the conduct of the business for which the organization was formed. Treasury Regulation Section 301.7701-1(c)(1). The Regulations further state that limited partnerships formed under statutes corresponding to the Uniform Limited Partnership Act generally do not have centralized management unless substantially all the interests in the partnership are owned by the limited partners. Treasury Regulation Section 301.7701-2(c)(4). The meaning of the term "substantial" as used in the Regulation is unclear. It appears likely that where the General Partner owns a 1% interest in the capital of the Partnership, such ownership is probably insufficient for the Limited Partners to be considered not to own substantially all the interest in the Partnership. It is assumed, for the purpose of this Memorandum only, that substantially all the interests in the Partnership are owned by the Limited Partners. It is therefore further assumed that the Partnership will have the corporate characteristic of centralized management.

3. Limited Liability. Under the Regulations, an organization has the corporate characteristic of limited liability if, under local law, there is no member who is personally liable for the debts of, or any claim against, the organization. Although the General Partner of the Partnership will be liable for the obligations of the Partnership, such liability will not be on a personal basis, since the corporate entity limits the liability of its owners.

Cases under the Internal Revenue Code provide additional requirements, however, for the avoidance of the corporate characteristic of limited liability in the situation where the sole general partner in a limited partnership is a corporation. The Regulations provide that limited liability exists where an individual general partner "has no substantial assets (other than its interest in the partnership) which could be reached by a creditor of the organization and is merely a "dummy" acting as the agent of the limited partners." Treasury Regulation Section 301.7701-2(d)(2) (emphasis added). Under this test, the Partnership is held not to have the corporate characteristic of limited liability if the General Partner has substantial assets or is not acting as a dummy for the Limited Partners. The Tax Court in Phillip G. Larson, 66 T.C. 159(1976) and the Court of Claims in Zuckman v. United States, 524 F.2d 729 (Ct. Cl. 1975), have applied this conjunctive test to limited partnerships having a sole corporate general partner.

As to the issue of what constitutes "substantial assets", the Service has announced, in Revenue Procedure 72-13, 1982-1 C.B. 735, that it will not rule favorably on the classification of a limited partnership with a sole corporate general partner unless, where the total contributions to that partnership are less than $2,500,000, the net worth of the general partner at all times is at least 15% of such total contribution. In computing the net worth of the general partner for

this purpose, the current Fair Market Value of its assets must be used, but any interest in, and accounts receivable and notes from the limited partnership must be excluded. If the General Partner has an interest in more than one limited partnership, the net worth requirements explained above must be applied separately for each limited partnership, and the general partner is required to have at all times a net worth (exclusive of any interest in or notes receivable from limited partnerships) at least as great as the sum of the amounts required for each separate limited partnership. Revenue Procedure 72-13 is applicable by its terms to the Partnership since there will be one corporate General Partner.

The General Partner has represented that its net worth, excluding its investment in the Partnership and any other limited partnership of which it is a general partner, is in excess of 15% of the aggregate investment in the Partnership plus the aggregate limited partner investment in all other limited partnerships of which the General Partner is a general partner. For this reason, the corporate characteristic of limited liability is not present.

4. Free Transferability of Interest. Treasury Regulation Section 301.7701-2(e) states that "an organization has the corporate characteristic of free transferability of interests if each of its members or those members owning substantially all the interests in the organization have the power, without the consent of other members, to substitute for themselves in the same organization a person who is not a member of the organization". The Regulations at Section 301.7701-3(b)(2) further provide that free transferability does not exist where each member can assign without the consent of the general partner only the right to share in the profits but cannot so assign the right to participation in management nor become a substituted limited partner. Under the Limited Partnership Agreement, a transferee of a Limited Partner will become a substituted Limited Partner in the Partnership only with the written consent of the General Partner, among other things, and this consent may be withheld at the complete discretion of the General Partner. Accordingly, the corporate characteristic of free transferability of interests is not present.

Thus, at least three of the four relevant corporate characteristics are not present. As such, there are not more corporate than partnership attributes present, and therefore, the Partnership should be treated as a partnership for Federal Income Tax purposes. However, no assurance can be given that legislative, judicial, or administrative changes will not occur which would render this conclusion obsolete.

The Service has set forth in Revenue Procedure 74-17, 1974-1 C.B. 438, certain requirements that must be satisfied before it will issue a ruling that a limited partnership will be treated by it as a partnership for Federal Income Tax purposes. The Partnership may not satisfy all these requirements. However, Revenue Procedure 74-17 specifically provides that the rules stated therein are not intended to be restatements of the law nor are they intended to be criteria to be applied on audit of returns. Additionally, the Service has recently promulgated Revenue Procedure 86-3, 1986-1 C.B. 26, which denies ruling

requests that a limited partnership will be classified as a partnership for tax purposes unless certain criteria are met. The Partnership may not meet these criteria either. However, while a Revenue Procedure does not have the force of law, it is an indication of the enforcement priorities of the Service. No ruling will, in fact, be sought from the Service on the partnership classification issue.

Taxation of Limited Partners

The Code provides that a partnership is not itself subject to Federal income taxation. Rather, each partner reports on his or her Federal Income Tax Return that partner's distributive share of the income, gains, losses, deductions, and credits of the partnership, whether or not any actual distribution of cash or property is made to such partner during the partner's taxable year. A limited partner of a partnership is generally entitled to deduct on his or her personal income tax return that partner's distributive share of partnership losses, if any, to the extent of the tax basis of his or her partnership interest at the close of the partnership's tax year.

If in any taxable year the Partnership were reclassified as an association taxable as a corporation, Partnership deductions, if any, would be available to the Partnership and not to a Limited Partner as an individual; the Partnership would be taxed on its profits; distributions to a Limited Partner would be treated as dividends to the extent of current and accumulated earnings and profits of the Partnership; and distributions in excess of earnings and profits would be treated as a return of capital to the extent of the Limited Partner's basis (which would not include any part of the Partnership's liabilities), with the amount received in excess of the Limited Partner's basis being treated as a capital gain (assuming the Units are capital assets in the Limited Partner's hands).

Basis and At-Risk Amount

The amount of any partnership loss or deduction for a partnership taxable year which a limited partner may use in computing his or her Federal income tax liability is limited to the adjusted basis of the limited partner's unit(s) determined at the close of such year, and also to the aggregate amount the limited partner is at-risk with respect to the partnership activity giving rise to the loss at the close of the partnership's taxable year.

As reflected in the Forecasts, the Partnership does not anticipate any net losses in any of its first five taxable years. Consequently, the basis and at-risk limitations are not expected to be material issues in the Offering.

The 1986 Tax Act further limits a limited partner's deduction of partnership losses (passive investment losses) to the net amount of passive income from other partnerships or similar entities. The General Partner does not believe this affects the Partnership or the Partners, since no tax losses are projected.

Depreciation Deductions

It is anticipated that the Partnership will acquire no material amount of personal property upon which cost recovery may be claimed.

Tax Treatment of Certain Allocations and Expenditures

The Partnership may incur certain costs, allocate income and losses, and make certain distributions for which there is a lack of clear authority regarding the proper tax treatment. Although the General Partner intends to rely on competent advisors in determining the tax treatment of these items, there can be no assurance that the Service will not take a contrary position regarding the tax treatment of these items. The treatment of certain of the more significant deductions and allocations is discussed below.

1. Allocations: The Code provides that, for Federal Income Tax purposes, each partner's share of the income, gain, loss, deduction, or item thereof of a partnership is determined by the partnership agreement unless the allocation under the partnership agreement does not have substantial economic effect. If the allocation contained in the partnership agreement does not have substantial economic effect, each partner's share of income, gain, loss, deduction, credit, or item thereof would be determined in accordance with the partner's interest in the partnership which, in turn, determined by taking into account all facts and circumstances relating to the interest, i.e., each partner's obligations with respect to contributions, participation in distributions, etc. These rules apply to overall allocations of profits and losses in the partnership agreement as well as to allocations of specific items of income, and deduction.

In December of 1985, the Treasury Department adopted regulations which contain novel and complex rules and examples relating to the "substantial economic effect" test and the determination of a partner's interest in a partnership. It is not entirely clear how the provisions of these regulations would be applied to each of the allocations contained in the Limited Partnership Agreement. In general, the regulations provide that the allocation of income, gain, loss, or deduction (or item thereof) in a partnership agreement to a partner has economic effect if: (i) capital accounts are maintained for each partner in accordance with Federal Income Tax accounting principles and appropriate adjustments are made to the partners' capital accounts; (ii) liquidation proceeds are, throughout the term of the partnership, distributed in accordance with the partners' capital account balances; and (iii) any partner with a deficit in his or her capital account following the distribution of liquidation proceeds is required to repay the amount of such deficit to the partnership which amount would be distributed to partners with positive capital account balances or paid to creditors. The regulations further state, that the fact that a partner is not required to restore the deficit in that partner's capital account does not invalidate an allocation to such partner to the extent that (i) the partnership agreement contains a "qualified income offset", and (ii) the allocation does not create a deficit in such partner's capital account at the end of the

partnership's taxable year. A qualified income offset provision is one which requires a partner who unexpectedly receives an adjustment, allocation, or distribution of certain types to be allocated items of income and gain to offset any deficit or increased deficit caused by the adjustment, allocation, or distribution as quickly as possible.

Under the Limited Partnership Agreement, capital accounts are maintained for each Partner in accordance with Federal Income Tax accounting principles and liquidation proceeds are distributed in accordance with the Partners' capital account balances throughout the term of the Partnership. Although under the Limited Partnership Agreement, a Partner is not required to repay to the Partnership the amount of any deficit in that Partner's capital account, based on the Forecasts, it is not anticipated that any Partnership allocation will create a deficit in the Limited Partners' capital accounts. Furthermore, the Limited Partnership Agreement, in Section VIII, provides for an income offset which the General Partner believes constitutes a qualified income offset within the meaning of the Treasury Regulations. Finally, allocations of profit and loss have been made to reflect actual cash distributions as closely as possible so as to lend little support to an argument that the allocations lack substantial economic effect.

As a result of the rules described above relating to when allocations in a partnership agreement will be given effect and the final regulations, there can be no assurance that the Service will not challenge one or more of the allocations made in the Limited Partnership Agreement. Such a challenge, if successful, could require the Limited Partners to recognize a smaller portion of the Partnership's losses or credits or greater share of the Partnership's income than the Limited Partnership Agreement provides.

2. Legal and Accounting Fees: The Partnership intends to amortize the costs, over a 60-month period, of various legal and accounting fees on the grounds that they are expenses connected with the organization of the Partnership. The remaining legal and accounting fees, which are related to this Offering, are to be capitalized and neither amortized nor deducted currently. There can be no assurance that the Service will not successfully contend that the amounts attributed to Partnership organization are more than is warranted or that a portion of such fees is related to the Offering and is not deductible or amortizable. If the Service prevails in such contention, Limited Partners will recognize a greater amount of taxable income over the period in which such fees would otherwise have been deducted.

3. Other Operating Expenditures: The Partnership plans to deduct other operating expenditures as set forth in the Forecasts. The General Partner believes that if the Service were to challenge the positions of the Partnership regarding such deductions as set forth in the Forecasts, the probable outcome of a challenge as to each material tax issue would be favorable to the Partnership. Nevertheless, if the Service were successful in challenging the treatment of such deductions, such a challenge would increase the amount of Partnership income set forth in the Forecasts, resulting in an increased tax burden upon the Limited Partners.

Sale or Other Disposition of a Unit

There is presently no market for the Units in the Partnership and none is expected to develop. In addition, the transferability of the Units is restricted by provisions of Federal and state securities laws and by the provisions of the Partnership Agreement. See "RISK FACTORS -- Restriction on Transfer of the Units." However, if a Limited Partner sells or exchanges a Unit, the gain or loss realized for Federal Income Tax purposes by the selling Limited Partner will be, in general, equal to the difference between the Limited Partner's adjusted tax basis in such Unit and the amount realized on such sale. The amount realized on the sale would include the selling Limited Partner's share of the Partnership's liabilities. Under law, such gain is long-term capital gain but, except for offsetting certain capital losses, is taxed at ordinary income gain rates. The selling Limited Partner will, however, realize ordinary income to the extent of gain attributable to "unrealized receivables" and "inventory items which have appreciated substantially in value" as defined in Section 751 of the Code.

Current tax law disallows preferential treatment for long-term capital gains. Long-term capital gains will be treated the same as ordinary income and taxed at the same rate as other kinds of taxable income.

Section 754 Election

The General Partner may be required in accordance with the Limited Partnership Agreement, to file an election under Section 754 of the Code to adjust the basis of the Partnership property in the case of a transfer of a Unit by sale or exchange or upon the death of a Limited Partner if the transferee becomes a substituted Limited Partner and requests the election in the manner provided in the Limited Partnership Agreement (assuming the election is not already in effect). The General Partner may also, in its discretion, make the election in the case of a transfer by sale or exchange or death, without a request to do so, as well as in other limited circumstances to which the election applies.

In the case of a transfer by sale or exchange or upon the death of the transferror, the election results in an adjustment to the basis of the Partnership's property (with respect only to the transferee Limited Partner) so that the transferee Limited Partner's proportionate share of the adjusted basis of the Partnership property equals the basis of his or her Unit. As a result, a transferee Limited Partner who purchases a Unit at a cost greater than the transferror's share of the Partnership's basis in its property will recognize in most circumstances less income (or more loss) upon the sale of Partnership property than if the election were not in effect, and may also in certain cases be entitled to larger ACRS deductions each year than if the election were not in effect. On the other hand, a transferee Limited Partner who purchases a Unit at a cost less than the transferror's share of the Partnership's basis in the Property will recognize, in most circumstances, more income (or less loss) upon the sale

of Partnership property than if the election were not in effect, and may be entitled to smaller ACRS deductions than if the election were not in effect.

A transfer by death is treated for this purpose as a purchase for the value of the Unit for federal estate tax purposes, which is, in general, the Fair Market Value of the Unit on the date of death or an alternate valuation date shortly thereafter.

The adjustments resulting from the foregoing election would be required to be reflected on the Limited Partner's individual tax returns, but would not be reflected in the financial or tax information to be provided the Partners by the Partnership.

Once the Section 754 election is made, it applies to all transfers by sale or exchange as well as in other circumstances, so that, if the Partnership makes the election after request of a transferee who obtains an advantage thereby, it will normally bind all future transfers even if the election is detrimental to them.

Complete Liquidation

In the event the Partnership is completely liquidated (which would occur after the termination of the Partnership), gain will be recognized by a Limited Partner upon receipt of a liquidating distribution only to the extent any money or property distributed exceeds the adjusted basis of such Partner's Unit(s). It is anticipated that, in a typical case, a Limited Partner's basis in such Unit will be approximately equal to his liquidating distributions. In such a case, little or no additional gain will be recognized as a result of receiving liquidating distributions. However, this will not necessarily be true and some or all of the Limited Partners may recognize a significant amount of gain on the liquidation of the Partnership. Loss will be recognized by a Limited Partner upon a liquidating distribution only if the Partner receives no property other than money, unrealized receivables and inventory, and then only to the extent that the adjusted basis of such Partner's Unit exceeds the sum of any money distributed and the basis to such Partner in the distribution.

Coordination of Pension Plans

Section 414(m) of the Code allows the Service, for the purpose of various employee benefit requirements (including qualified retirement plans), to treat all employees of the members of an affiliated service group as employed by a single employer. Section 414(m) contains a complicated definition of "affiliated service group" which is not entirely clarified by the Treasury Regulations. Although the purpose of the Section is to prevent abuses by professional practices whose individual professionals incorporate to take advantage of corporate retirement benefits, the language of the statute is much broader. Furthermore, its interpretation by the Service and the courts has not been significantly developed to date.

If Section 414(m) were found to apply, all corporate employee benefits among the members of the affiliated service group would have to be equalized, which could result in increased costs. In the case of the Partnership, there is a possibility that, upon audit, the Service may hold that the General Partner, or Limited Partners, perform services for, or are regularly associated in the performance of services with, the Limited Partnership, or that an affiliated service group exists for some other reason. The General Partner believes that although such an interpretation appears unlikely, there is a significant risk that the Partnership may have to provide pension benefits for its employees that are comparable to the pension plans of some or all of the Partners, including the General Partner, to avoid exposing existing pension benefit plans of some or all of the Partners, including Limited Partners to loss of some or all of the tax-favored treatment generally accorded to tax-qualified plans. Prospective investors should consult their own tax advisors to evaluate the possible impact of this risk in their specific situations.

Tax Audits

The Partnership will furnish annually to the Limited Partners (but not to assignees of Limited Partners unless they become substitute Limited Partners) sufficient information from the Partnership's tax returns for the Limited Partners to prepare their own Federal, state and local tax returns.

The Service has announced a policy of auditing substantially more partnerships than in the past. The 1982 Tax Act established a new partnership audit procedure under which the tax treatment of the partnership's income, gains, losses, deductions, and credits will, in most cases, be determined by a unified audit of the partnership rather than by separate audits of the tax returns of the limited partners. The Service will not be required to give notice of administrative proceedings and adjustments with respect to the Partnership's returns to any Limited Partner having less than a one percent interest in the profits of the Partnership. Any Limited Partner who purchases the minimum two Units will have less than such one percent interest.

The Limited Partnership Agreement designates the General Partner as the "tax matters partner" to act on behalf of the Partnership in connection with an audit or other proceeding relating to the Partnership's Federal Income Tax Returns. As such, the General Partner will have substantial responsibilities in connection with any such proceeding including the ability to agree to extend the statute of limitations with respect to all Partnership items for all Partners. Under the Code and Treasury Regulation Section 301.622(a)-1 the tax matters partner is not required to provide notice of any proceeding to the partners. Consequently, a Limited Partner who wishes, for example, to be present during a preliminary discussion between an examining agent and the tax matters partner should make special arrangements with the tax matters partner to obtain information as to the time and place of the discussion. However, the Limited Partnership Agreement requires the General Partner to notify the Partners of any and all

administrative and judicial proceedings relating to the adjustment, at the Partnership level, of Limited Partnership tax items, except for routine or minor events.

In the event any of the tax returns of the Partnership are audited, it is possible that substantial legal and accounting fees will have to be paid by the Partnership and/or the Limited Partners to contest any adjustments proposed upon audit. If any such audit results in final adjustments to the Partnership's tax return, an adjustment to each Limited Partner's personal return will be required. An audit of the Partnership's tax returns may also result in an audit of both Partnership and non-Partnership items on a Limited Partner's tax return, which in turn could result in adjustments to such items. The Partnership and the General Partner are not responsible for any additional tax or expense incurred by a Limited Partner resulting from such adjustments.

Penalties and Interest

The 1982 Tax Act imposes a penalty on taxpayers who substantially understate their tax liability. For purposes of this penalty, a "substantial understatement" of tax liability exists if the liability reported on the return understates the correct liability by the greater of 10% of such liability or $5,000 ($10,000 for corporations other than S corporations and personal holding companies). In general, the penalty is an amount equal to 20% of the understatement of tax liability. However, for purposes of this provision, the amount of an "understatement" is reduced by the portion thereof which is attributable to the tax treatment of any item by the taxpayer if there was or is "substantial authority" for such treatment.

The legislative history of the provision imposing the penalty indicates that the "substantial authority" standard was intended by Congress to be less stringent than a "more likely than not" standard and more stringent than a "mere reasonable basis" standard and that the weight of authority supporting the taxpayer's position must be "substantial" when compared to the authorities supporting other positions. In addition, the penalty does not apply to any understatement or portion thereof which is attributable to any item with respect to which the relevant facts affecting the item's tax treatment were adequately disclosed in the taxpayer's return or in a statement attached thereto.

However, if an item is attributable to a "tax shelter", the penalty can be avoided only if the taxpayer had "substantial authority" for such treatment and the taxpayer reasonably believed that the tax treatment of such item was "more likely than not" the proper treatment, a stricter standard than is applied to non-tax shelter items. The penalty cannot be avoided by disclosing the relevant facts affecting the tax treatment of an item attributable to a "tax shelter". A tax shelter for this purpose means a partnership, entity, plan, or arrangement the principal purpose of which is the avoidance or evasion of Federal Income Tax. The Partnership does not anticipate that this would be the principal purpose for which persons would acquire Units.

If the tax treatment of any item by the Partnership were to be successfully challenged by the Service, the Service might also assert that this penalty applies to some or all of any resulting understatement of a Limited Partner's income tax.

Treasury Regulations implementing the "substantial understatement" rules were adopted in March of 1985. Under these Regulations, the existence of "substantial authority" and "reasonable belief" are determined at the entity level in the case of items attributable to the Partnership. Thus, for example, the disclosure of relevant facts relating to a Partnership item for which there is not substantial authority (and which is not a tax shelter item) would have to be made on a Partnership's return and not the return of a Partner, in order to avoid imposition of a penalty. These Regulations contain an automatic waiver of the penalty, however, if the Partner makes adequate disclosure on his or her return of information identifying the item, its amount, and the facts affecting the tax treatment of the item that reasonably may be expected to apprise the Service of the nature of the potential controversy concerning the tax treatment of the item. Disclosure of a Partnership item is deemed "adequate" only if a copy of the disclosure notice is attached to the Partner's return and a second copy is filed with the Service Center where the Partnership's return is required to be filed. Under these Regulations, the reasonable belief of a Partner as to the proper treatment of a Partnership item would not affect the imposition of the penalty in the case of a partnership determined to be a "tax shelter".

The 1984 Tax Act imposed a higher rate of interest for any interest accruing after December 31, 1984, with respect to a substantial underpayment of tax attributable to a tax-motivated transaction, which rate is 120% of the normal annual interest rate upon deficiencies. If any loss or credit taken by any Partner is disallowed and the underpayment of tax which had resulted from these deductions or credits was greater than $1,000 for the year in question, then the higher rate of interest will apply to the tax deficiency until paid.

The General Partner intends to avoid the imposition of any penalties. To the extent positions taken on Partnership tax returns are deemed controversial by the General Partner, the General Partner will consult with its tax advisor as to whether substantial authority exists for the position taken. Appropriate disclosure will be made to the Service on the Partnership's return, and to the Partners for use in preparing their individual returns.

Registration of Tax Shelters

The 1984 Tax Act added provisions requiring the registration of many forms of investment which have tax shelter potential. The definition of the type of investment which must be registered is very broad and in the opinion of the General Partner, this Partnership may come within this definition. However, under Temporary Regulations issued by the Treasury Department, even though an investment meets this definition, the organizer need not register the investment with the Service as a "tax shelter" if it is a "projected income investment."

Temp. Reg. Section 301.6111-1T, A-57H provides that a tax shelter is projected income investment if it is not expected to reduce the cumulative tax liability of any investor for any year during any of the first five years of the partnership. In the opinion of the General Partner, the Forecasts adequately indicate that reduction of tax liability for any Partner is not anticipated, and therefore the Partnership need not be registered as a tax shelter under the projected income investment exception. Accordingly, the Partnership has not registered under these sections of the Internal Revenue Code as added by the 1984 Tax Act.

XV. STATE AND LOCAL TAX ASPECTS

Each Limited Partner is required to represent that he or she is a resident of the State of Tennessee. As a result of their ownership of Units, Limited Partners may be subject to state and/or local taxes imposed by the State of Tennessee and political subdivisions thereof. It is important for each investor to consult his or her own tax advisor to determine his or her potential tax liability for other state and local taxes.

XVI. ALLOCATION OF PROFITS AND LOSSES FOR INCOME TAX PURPOSES

Net profits and losses of the Partnership shall initially be allocated 99% to the Limited Partners and 1% to the General Partner until the Limited Partners receive $150,000 in cash distributions. At that time, the General Partner will receive 50% of all subsequent cash distributions until the General Partner has been reimbursed the $150,000 advanced to the Partnership for Development Costs. When the Limited Partners receive $150,000 in cash distributions, the Partnership will be responsible for paying the marketing costs as they are incurred. After the Limited Partners receive $300,000 in cash distributions and the Development Costs have been reimbursed to the General Partner, the General Partner will receive 50% of subsequent cash distributions until all advanced marketing costs have been reimbursed. After all the aforementioned have occurred, the net income and losses will be allocated 99% to the Limited Partners and 1% to the General Partner. The allocation of the profits and losses among the Limited Partners shall be on a proportionate basis. Profits or losses from the sale or disposition of the Project are to be determined after all customary expenses associated with the business have been paid.

XVII. CASH DISTRIBUTIONS TO PARTNERS

Distribution of Cash from Operations

Funds available for distribution to the Partners ("Distributable Funds") shall be calculated after the allocation by the General Partner, in its sole discretion, of a reserve for the conduct of the Partnership's business, including repairs, replacements, property taxes and insurance, future payments of anticipated obligations, and contingent liabilities, if any. Distributable Funds shall then be distributed to the Partners in the same manner as net profits and losses are allocated.

Distribution of Cash from Sales, Refinancing, and Dissolution

Cash from sales of Partnership assets, cash from refinancing and cash available for distribution upon a dissolution will be distributed in the following order of priority (or in accordance with capital account balances which have been adjusted so as to result as nearly as possible in distribution substantially as follows):

1. To creditors, in the order of priority as provided by law;

2. To any reserves which the General Partner may deem necessary for contingent or unforeseen liabilities of the Limited Partnership (which reserves will be held in trust);

3. To the Partners for the repayment of any debts owing for loans or advances made to, or for the benefit of, the Limited Partnership;

4. To the Partners to the full or pro rata extent of the undistributed balance of the capital account of each; and

5. The balance, if any, to the Partners in the ratio of their respective capital accounts immediately prior to dissolution.

XVIII. SUMMARY OF LIMITED PARTNERSHIP AGREEMENT

The rights and obligations of the Partners are governed by the Limited Partnership Agreement set forth in its entirety in this Memorandum as Appendix C. THE FOLLOWING STATEMENTS AND OTHER STATEMENTS IN THIS MEMORANDUM CONCERNING THE LIMITED PARTNERSHIP AGREEMENT ARE MERELY A SUMMARY AND DO NOT PURPORT TO BE COMPLETE AND IN NO WAY MODIFY OR AMEND THE LIMITED PARTNERSHIP AGREEMENT. THE FOLLOWING SUMMARY IS QUALIFIED IN ITS ENTIRETY BY REFERENCE TO THE LIMITED PARTNERSHIP AGREEMENT. Accordingly, each prospective investor is urged to study carefully all the terms and provisions of the Limited Partnership Agreement before executing the Subscription Agreement (Appendix D).

Capital Contributions

The General Partner will make a cash capital contribution of $3,000 to the Partnership. The Limited Partners will make a cash capital contribution of $297,000.

Limited Liability

No Limited Partner shall be liable for the debts, liabilities, contracts, or any other obligations of the Partnership. Except for the cash capital contribution, no Limited Partner shall be obligated to make additional capital contributions to the Partnership. If prior distributions to a Limited Partner have caused his or her capital contribution to be less than as set forth in the Limited Partnership Agreement, the Limited Partner may be required to make up the differ-

ence with interest to satisfy the Partnership's liability to any creditors who extend credit or whose claims arose before the Limited Partnership Agreement is amended to reflect such distribution. The General Partner has no obligation to cause such amendment to be made.

Termination, Dissolution, and Liquidation

The Partnership shall be dissolved 20 years from the date on which the Certificate of Limited Partnership is filed unless one of the contingencies specified in Section XII of the Limited Partnership Agreement occurs before that time, in which case the Partnership will be dissolved upon the first to occur of such contingencies. Such contingencies include the consent of the General Partner and a majority of the Limited Partners; the consent of all Limited Partners; the withdrawal, removal, bankruptcy, or dissolution of the last remaining person or entity constituting the General Partner; the bankruptcy or insolvency of the Partnership, or the sale of all Partnership assets and distribution of the proceeds.

Upon dissolution, the assets of the Partnership shall be liquidated and, after Partnership obligations to third parties have been discharged or provided for, the net proceeds of such liquidation shall be distributed to the Partners in the manner described under "CASH DISTRIBUTIONS TO PARTNERS -- Distributions of Cash from Sale, Refinancing, and Dissolution". For a description of the Federal Income Tax consequences of such liquidation distributions, see "FEDERAL INCOME TAX ASPECTS -- Complete Liquidation".

Management of Partnership

The Partnership shall be managed by the General Partner. All decisions of the General Partner shall be made by or under the direction of its Board of Directors. The General Partner shall have full and exclusive discretion to take, without the consent of the Limited Partners, any and all action of whatever type the Partnership is authorized to take and to make all decisions with respect thereto and to exercise on behalf of the Partnership all powers and rights necessary or convenient to effectuate and carry out the purposes and business of the Partnership. The General Partner shall not, in its capacity as General Partner, receive any salary, fees, profits, or distributions except profits, distributions, fees, and allocations to which it may be entitled as described in "COMPENSATION, FEES, AND INTEREST IN THE PARTNERSHIP" and under the provisions of the Limited Partnership Agreement. The Partnership shall reimburse the General Partner for all expenses incurred by it on behalf of the Partnership.

The Limited Partnership Agreement specifically authorizes the General Partner, on behalf of the Partnership, to enter into certain transactions, including transactions with affiliates, such as expending Partnership funds, borrowing money in the name of the Partnership, employing persons, contracting with interpreting physicians, and entering into agreements on behalf of the Partnership in the ordinary course of the Partnership's business. The General Partner is also appointed tax matters partner for purposes of the Internal Revenue

Code, and, as such, shall keep the Partners informed of any and all administrative and judicial proceedings relating to the adjustment, at the Partnership level, of Limited Partnership tax items, except for routine or minor events.

The Medical Advisory Board will only make recommendations to the General Partner, they will have no voice in the management of the Partnership or the Center.

Working Capital

The General Partner, at its sole option, may provide working capital in the form of a loan to the Partnership. Any such working capital loan shall be provided by the General Partner at a interest rate of prime plus 3%, but not in excess of the highest rate permitted by law with such interest on the outstanding balance (principal and accumulated interest) payable at the end of each month. Working capital is defined as the capital necessary to run the business and operations of the Partnership, exclusive of any acquisition costs of equipment.

Restrictions on Transfer of Units

No Limited Partner may transfer or encumber any Units without complying with the provisions of the Limited Partnership Agreement. In addition, transfer of the Units is restricted by both Tennessee and Federal securities law and by the Subscription Agreement.

Option to Repurchase Units

Under Sections 10.7 of the Limited Partnership Agreement, the Partnership may repurchase the Unit(s) of any Limited Partner in the event that this type of Partnership is declared illegal. The purchase price for this option is set forth in Sections 10.7.2 of the Agreement.

Removal of General Partner

The General Partner may be removed upon the vote of Limited Partners representing 90% of the Units outstanding. However, the General Partner is not prohibited from purchasing Units with full voting rights. If the General Partner does purchase a sufficient number of Units, it will effectively prevent its removal as General Partner. The General Partner may purchase any Units if such Units remain unsold at the close of the Offering. Its shareholders or affiliates may also purchase Units. Ownership of Units by shareholders and affiliates of the General Partner would similarly be effective to prevent the removal of the General Partner.

Amendment

The Limited Partnership Agreement may be amended by (i) a proposal in writing by the General Partner or by 50% of the Limited Partners, and (ii) a subsequent written approval by the General Partner and Limited Partners holding 90% of the Units. No amendment may change the rights and liabilities of the Limited Partners without the consent of 90% of

the Limited Partners. The Limited Partnership Agreement grants the General Partner broad discretionary authority to amend the Limited Partnership Agreement to conform it to law. The General Partner and its affiliates may purchase Limited Partnership Units on the same basis as the Limited Partner investors. If the General Partner or its affiliates purchase enough Limited Partnership Units, they could effectively ratify, enact, or defeat any amendment.

Meetings

The Limited Partnership Agreement provides that the Limited Partners, by consent of Limited Partners representing 25% of the Units outstanding, may call a meeting and makes no other provision for meetings of Partners. The General Partner does not intend to hold annual or other meetings of Partners.

Books and Records

The General Partner will cause full and accurate books to be kept by the Partnership. All books and records of the Partnership will be kept at the Partnership's principal office and shall be available at reasonable times for inspection and copying by the Limited Partners or designees on ten-days' notice. The books of the Partnership will be kept on a cash basis or such other basis as the General Partner may determine. A capital account for each Partner will be maintained as part of the books of the Partnership and the amount of profits and losses of the Partnership, as well as capital contributions to the Partnership and distributions from the Partnership, will be credited or charged, as the case may be, to the capital account of the Partner, in accordance with applicable Treasury Regulations.

Additional Information

The Partnership will provide any prospective investor, at any reasonable time prior to purchase, the opportunity to ask questions and receive answers concerning the terms and conditions of this Offering and to obtain any additional information which the General Partner possess, or can acquire by reasonable effort or expense, that is necessary to verify the accuracy of the information furnished by the Partnership in this memorandum or otherwise. Any offeree may contact a Director of the General Partner at any time during business hours for this purpose. Except as otherwise indicated, this Memorandum speaks as of the date appearing on the cover page hereof, and neither the delivery hereof nor the purchase of interests shall under any circumstances, create an implication that there has not been a change in the affairs of the Partnership since the respective date at which the information is given herein or the date hereof.

Schedule of Available Documents

The following documents are available for inspection by investors during regular business hours at the place of business of the General Partner:

1. Facility Lease.

2. Radiology Consultants, Inc., Interpretation Contract.

3. Various Notes, Lease Agreements, Consulting Contract with The Cooperative, etc.

4. Escrow Agreement with Third National Bank.

Tax Elections

The General Partner may cause the Partnership to make such elections as the General Partner deems appropriate in its sole discretion.

Financial Statements; Tax Information

As soon as possible after the end of each fiscal year of the Partnership, each Limited Partner will be furnished with a report of the business and operations of the Partnership during such fiscal year. This report shall constitute the accounting of the General Partner for such fiscal year.

Appropriate tax information will be delivered to each Limited Partner as soon as possible after the end of each calendar year including adequate information relating to the Partnership to enable each Limited Partner to complete and file his Federal and State tax returns.

Liability of the General Partner

According to Section 15.2 of the Limited Partnership Agreement the doing of or failure to do any act by the General Partner shall not subject the General Partner to any liability to the Partnership or the Partners, except for gross negligence or willful malfeasance.

Insofar as indemnification for liabilities arising under the Securities Act of 1933 may be permitted to the the General Partner, or its directors, officers, or controlling persons pursuant to these provisions of the Limited Partnership Agreement, the General Partner has been informed that in the opinion of the Securities and Exchange Commission such indemnification is against public policy and therefore unenforceable.

XIX. TO PARTICIPATE IN THE OFFERING

To purchase any Units, the subscriber must complete, sign, and return in accordance with the Subscription Agreement the following documents: (i) the Subscription Agreement and Signature Page, (ii) the Signature Page of the Limited Partnership Agreement, and (iii) a check or money order in the amount of $1,000 per Limited Partnership Unit made payable to Nashville Imaging Center, L.P.

By executing the Subscription Agreement, the subscriber: (i) agrees to all the terms of the Limited Partnership Agreement, (ii) grants the Power of Attorney contained in the Subscription Agreement, and (iii)

adopts and agrees to all the terms, conditions, and representations contained in the Subscription Agreement (which includes representations as to investor suitability and relating to availability of exemptions from registration for the Offering). The Limited Partnership Agreement is set forth in full as Appendix C to this Memorandum, and the provisions thereof are summarized under the caption "SUMMARY OF LIMITED PARTNERSHIP AGREEMENT". The General Partner will sell Units only to subscribers who meet the investor suitability standards imposed by the Partnership.

The General Partner intends to terminate the Offering of the Units of this Partnership on May 17, 1988. However, the Offering period may be extended to July 18, 1988 or such other earlier date as the General Partner determines, in its sole discretion. An escrow account has been opened with the Third National Bank. All funds tendered will be held on deposit in this account until the close of the Offering. If all 297 Units have not sold prior to July 18, 1988 or sooner, the Offering will be terminated and all funds tendered by subscribers will be returned without interest.

All tendered subscriptions are subject to acceptance by the General Partner, and may be partially accepted by the General Partner, in its discretion, if the Offering is oversubscribed. The General Partner may, but is not obligated to, purchase Units on the same terms as other investors, assuming that any Units remain unsold after the closing of this Offering. Affiliates of the General Partner may also purchase Units.

XX. FINANCIAL FORECASTS

The calculations and discussions of projected operating results in the Forecasts (Appendix B) including the various schedules, forecasts, and statements concerning tax consequences are based on estimated gross billings, operating expenses, and various other assumptions made by the General Partner set forth therein. The Forecasts are included for the information and convenience of the investor. The Forecasts have been prepared in consultation with the General Partner by The Cooperative, Del Mar, California.

THE FORECASTS ARE BASED ON ASSUMPTIONS AS TO FUTURE EVENTS AS WELL AS FEDERAL INCOME TAX LAWS WHICH ARE SUBJECT TO INTERPRETATION AND CHANGE. See "FEDERAL INCOME TAX ASPECTS". THE FORECASTS SHOULD MERELY BE VIEWED AS AN ORDERLY REPRESENTATION OF THE RESULTS THAT MIGHT BE ACHIEVED SHOULD ALL OF THE STATED ASSUMPTIONS BE REALIZED. NO ASSURANCE CAN BE GIVEN AS TO THE PROBABILITY THAT THE FORECASTED RESULTS WILL BE ACHIEVED.

The Forecasts are based on information furnished by the General Partner and assumptions as to income, expenses, cash flow, timing of construction, and other matters, and on current federal income tax law and regulations, as described in the assumptions and notes to the Forecasts and elsewhere in this Memorandum.

The Forecasts are based on estimates and assumptions which represent the General Partner's best judgment as to what the actual experiences of the Partnership will be. In certain circumstances, however, some assumptions have been arbitrarily chosen for the purposes of these Forecasts because of the impossibility of making meaningful, precise, predictive assumptions or because of the possibility of offsetting changes in assumed facts. Changes in assumptions, estimates, and forecasts, particularly as to achievement of operating expenses, and local taxes (each of which may be higher or lower than projected) and as to federal tax matters (which are subject to change) could vary actual operating results from those which have been projected.

The profits and losses allocated to the Limited Partners in the Forecasts are the projected profits and losses allocable to the Limited Partners for federal income tax purposes given the estimates and assumptions upon which the Forecasts are based. However, there can be no assurance that the treatment of items in the Forecasts will not be adjusted by the Service upon examination. (See "RISK FACTORS.") Such adjustments could include, among other things, a disallowance of all or part of the deductions taken by the Partnership or an adjustment to the allowable depreciation (see "FEDERAL INCOME TAX ASPECTS"). The General Partner does not intend to issue any updated Forecasts to the Limited Partners after the closing of this Offering, even if actual results of operation vary or are expected to vary from the Forecasts.

EACH PROSPECTIVE INVESTOR SHOULD CONSULT HIS OR HER OWN TAX OR INVESTMENT ADVISOR TO DETERMINE THE RELEVANCE OF THE FORECASTS TO HIS OR HER INDIVIDUAL SITUATION.

XXI. GLOSSARY

As used in the Memorandum, the following terms have the definitions indicated:

"Adjusted Capital Contribution" means the amount of cash actually contributed to the Partnership by a Limited Partner minus the amounts of any prior distributions to such Limited Partner of Cash from Refinancing or Cash from Sales.

"Affiliate" means with respect to a corporation: (i) any officer, director, employee, or shareholder of such corporation; (ii) any corporation, partnership, trust, or other entity controlling, controlled by, or under common control with such corporation, or any person described in (i) above; (iii) any officer, director, trustee, general partner, or employee of any person described in (ii) above; and (iv) any person who is a member, other than as Limited Partner, with any person described in (i) and (ii) above in a relationship of joint venture, general partnership, or similar form of unincorporated business association. For purposes of this definition, the term "control" shall mean the control or ownership of 25% or more of the beneficial interest in the person referred to.

"Bankruptcy" means the filing of a voluntary case in bankruptcy under the federal bankruptcy law and, in addition, any other status constituting bankruptcy within the meaning of the Bankruptcy Act.

"Cash from Operations" means all cash of the Partnership arising from its operations other than Cash from Sales or Cash from Refinancing, net of (a) all cash required to pay Partnership liabilities which are then due, and (b) reasonable reserves established by the General Partner in its sole discretion for working capital and the satisfaction of liabilities (including contingent liabilities) as they come due or may become due.

"Cash from Refinancing" means the net cash proceeds realized by the Partnership from financing or refinancing of any of the Partnership's assets or the refinancing of any Partnership indebtedness after deduction of all expenses incurred in connection therewith and payment of the indebtedness being refinanced and payment of interest and principal on loans, less such amounts for reserves as the General Partner deems reasonably necessary for future Partnership operations and plus any cash released from such reserves.

"Cash from Sales" means the net cash proceeds realized by the Partnership (after deduction of all other related expenses) from the sale, exchange, condemnation, or other disposition of all or substantially all of its personal property and any insurance proceeds received by the Partnership from any insurance policy insuring against physical damage of Partnership assets, after deduction of all expenses incurred in connection therewith and payment of any underlying indebtedness related to the assets sold or disposed of and any other expenses of the Partnership, less such amount for working capital reserves for future Partnership operations and plus any cash released from such reserves.

"Cash Investment" means the initial cash contribution from a Limited Partner.

"Fiscal Year" means the year ending December 31.

"Forecasts" means the prospective financial statements that present to the best of the General Partner's knowledge and belief, the Partnership's expected financial position, results of operations, and changes in financial position based upon the General Partner's assumptions reflecting conditions they expect to exist and the course of action they expect to take attached to this Memorandum as Appendix B.

"General Partner" means Quantum Corporation, a Tennessee professional S corporation, and any other person or entity admitted as a General Partner pursuant to the Limited Partnership Agreement and their respective successors as General Partner of the Partnership, collectively or individually as the context requires.

"Limited Partner" means any person or entity in his or her capacity as a Limited Partner of the Partnership and whose name and address is set forth on the Signature Page of the Limited Partnership Agreement and any other person admitted to the Partnership as a Limited Partner or substituted Limited Partner.

"Limited Partnership Agreement" means the Limited Partnership Agreement, as amended, attached to this Memorandum as Appendix C.

"Memorandum" means this Private Placement Memorandum.

"Partner" means any General Partner or Limited Partner of the Partnership.

"Partnership" means Nashville Imaging Center, L.P., a Delaware Limited Partnership.

"Person" means any natural person, corporation, partnership, trust, or other entity.

"Project" means the business of the Partnership, as described in "PARTNERSHIP BUSINESS" in this Memorandum.

"Radiologist" means an independent physician or his or her professional corporation licensed to practice medicine in the State of Tennessee.

"Securities Act" or "Act" means the Securities Act of 1933, as amended.

"Signature Page" means the signature page for the Limited Partnership Agreement and Subscription Agreement.

"Subscription Agreement" means that agreement for subscription of Partnership Units attached to this Memorandum as Appendix D.

"Unit" means one unit of limited partnership interest in the Partnership.

APPENDIX A

NASHVILLE IMAGING CENTER, L.P.

PARTNERSHIP INITIAL BALANCE SHEET

BALANCE SHEET

ASSETS

Current Assets

Limited Partners:		
Cash	$ 297,000	
General Partner:		
Cash	3,000	
Advance	150,000	
TOTAL ASSETS		$450,000

LIABILITIES & EQUITY

Current Liabilities

Development Costs	$ 150,000	
Equity	$ 300,000	
TOTAL LIABILITIES & EQUITY		$450,000

* Initially, the General Partner will pay the Development Costs. After the Limited Partners receive $150,000 in cash distributions, the General Partner will receive one-half (50%) of all cash distributions until the General Partner is reimbursed the advanced Development Costs.

The General Partner will also advance all marketing costs until the Limited Partners receive $150,000 in cash distributions. After the Limited Partners receive $150,000 in cash distributions, the Partnership will pay for the marketing costs as they are incurred. After the Limited Partners receive $300,000 in cash distributions and the General Partner is reimbursed for the Development Costs, the General Partner will receive one-half (50%) of all cash distributions until the General Partner is reimbursed for all advanced marketing costs.

After both the Development Costs and advanced marketing costs are reimbursed to the General Partner, the cash distributions will be allocated 99% to the Limited Partners and 1% to the General Partner.

April 4, 1988

APPENDIX B

FINANCIAL FORECAST

PREPARED FOR

NASHVILLE IMAGING CENTER, L.P.

A DELAWARE LIMITED PARTNERSHIP

BY

THE COOPERATIVE

SUMMARY OF SIGNIFICANT FORECAST ASSUMPTIONS

This financial forecast presents, to the best of the General Partner's knowledge and belief, the Partnership's expected results of operations for the forecast period. Accordingly, the forecast reflects its judgment of the expected conditions and its expected course of action as of the date of this forecast. The financial forecast is based on the General Partner's assumptions concerning future events and circumstances. The assumptions disclosed herein are those which the General Partner believes are significant to the forecast or are key factors upon which the financial results of the project depend.

The forecast is based on assumptions made by the General Partner which reflect conditions they expect to exist and the course of action it expects the Partnership to take. The General Partner believes the assumptions are reasonable and appropriate and are consistent with the anticipated operation of the Partnership. However, the results of operations shown by the forecast depend heavily on the assumption regarding the number of imaging procedures to be performed per day, and which will be performed by the Partnership. The number of imaging procedures used in the forecast is essentially the average case achieved nationwide by imaging centers using similar equipment.

ASSUMPTIONS

1. A 1.5 Tesla MR scanner and a high-quality CT scanner costing a total of $2,900,000 (including taxes) are leased for 60 months at $53,360 per month. Furniture and fixtures costing $50,000 and leasehold improvements of $200,000 are financed over 60 months at $5,741 per month. Until construction of the fixed-unit site is complete, a mobile MR system will be leased for $52,500 per month. Lease payments will be made in cash. The fixed-site MR and CT Center is anticipated to open in October 1988.

2. The Partnership will lease 4,500 square feet of improved space for approximately $8,000 per month.

3. All variable (per scan) expenses, labor expenses, and a portion of fixed expenses will remain constant.

4. Technical fees average $600 per MR scan and $400 per CT scan. Collections are 85% of billings. Cash is collected over a five-month period. Professional fees are 20% of global cash collections.

5. The average number of MR scans per day starts at 10 and increases to 13 in 1988 and to 16 in 1993. The average number of CT scans per day starts at 6 in 1988 and increases to 10 in 1991.

6. Total financial risk is approximately $3,700,000 for the Partnership. The 297 Limited Partnership units will contribute $297,000 in cash. Each Limited Partnership unit will cost $1,000 in cash. As a group, the purchasers of the Limited Partnership units will receive 99% of the cash distributions.

   The General Partner will contribute $3,000 in cash and be responsible for the remaining Partnership obligations. The General Partner will receive 1% of the cash distributions.

The General Partner will advance Development Costs of $150,000 and all marketing costs until the Limited Partners receive $150,000 in cash distributions. At that point, the General Partner will receive 50% of the cash distributions until they are reimbursed the $150,000 in Development Costs and the Partnership will be responsible for paying all the marketing costs as they are incurred. After the Limited Partners receive $300,000 in cash distributions and the General Partner is reimbursed the advanced Development Costs, the General Partner will receive 50% of the cash distributions until they are reimbursed the advanced marketing costs. After such time as the advanced Development Costs and marketing costs are reimbursed to the General Partner, the cash distributions will be distributed 99% to the Limited Partners and 1% to the General Partner.

7. The Limited Partners will own 99% of the assets of the Partnership and the General Partner will own 1%.

8. The General Partner will own the facility. They will lease the facility to the Partnership at their cost for the initial lease period. The lease will be for a five-year period with three options to extend the lease at Fair Market Value for five years per option.

TABLE OF CONTENTS

Page 4 Six-year Summary: Projects the operation over a six-year period. The bottom of the page shows the net income from a cash investment and the corresponding income in Limited Partnership units.

Page 6 Financial Variables - 1988: Shows variables most likely to change from case to case, projected scans and a cash flow summary showing the effects on the cash balance.

Page 7 Expenses - 1988: All variables and fixed expenses are totaled at the bottom of the page under operating expense. Shows salary and fringe benefit expenses incurred each month. Salary expenses and operating expenses are added to give the total expenses incurred monthly.

Page 8 Cash Flow Cycle - 1988: Shows when cash is received. The receipts are equal to the technical fee times the collection rate. Each month's fees are collected over a five-month period at the following collection curve.

Month	1	2	3	4	5
Percent	5%	11%	52%	22%	10%

Page 11 Five-Year Purchase Schedule: Shows payments for the loan for furniture, fixtures, and leasehold improvements.

Notes: All pages remaining are identical to their respective year.

All figures are rounded to the nearest dollar amount so some totals may appear one dollar off.

NASHVILLE

SIX-YEAR SUMMARY

YEAR	1988	1989	1990	1991	1992	1993
AVERAGE MR SCANS/DAY	12	13	14	15	16	16
MR SCANS/YEAR	2220	3120	3360	3600	3840	3840
FEE PER SCAN	600	600	600	600	600	600
AVERAGE CT SCANS/DAY	7	8	9	10	10	10
CT SCANS/YEAR	420	1920	2160	2400	2400	2400
FEE PER SCAN	400	400	400	400	400	400
CASH CONTRIBUTIONS	300000					
INCOME STATEMENT						
CASH RECEIPTS	877234	2228496	2448000	2652000	2774400	2774400
LESS: EXPENSES	-836062	-1939906	-2021215	-2038025	-2046430	-2040779
NET INCOME	41172	288590	426785	613975	727970	733621
CUMULATIVE INCOME	41172	329762	756547	1370522	2098492	2832112
CASH FLOW FROM OPERATION	50062	310750	453891	635388	742968	735039
TOTAL CASH DISTR.		305406	422297	635388	742968	735039
CUMULATIVE		305406	727703	1363091	2106058	2841097

AT-RISK INVESTMENT FOR 10 LP UNITS: $10,000
CASH DISTRIBUTED:

DISTRIBUTION:	ANNUAL	10180	14077	21180	24766	24501
	CUMUL.	10180	24257	45436	70202	94703

PRE-TAX ANNUAL INTERNAL RATE OF RETURN

78%

NASHVILLE

SIX-YEAR CASH SUMMARY

	1988	1989	1990	1991	1992	1993
BEGINNING CASH BALANCE		350062	200000	200000	200000	200000
CASH CONTRIBUTIONS	300000					
LOAN PROCEEDS	250000					
SYSTEM ACQUISITION	-250000					
PRINCIPAL PAYDOWN	-3110	-39841	-44893	-50587	-57003	-58581
DEV. EXPENSE RECOVERY		-150000				
MKTNG EXPENSE RECOVERY		-5406	-31594			
AMORTIZATION & DEP'N	12000	62000	72000	72000	72000	60000
NET INCOME	41172	288590	426785	613975	727970	733621
CASH TO INVESTORS		-305406	-422297	-635388	-742968	-735039
ENDING CASH BALANCE	350062	200000	200000	200000	200000	200000

[NASH6CL]

ASHVILLE

1988 FIRST YEAR OF OPERATION
12 MR SCANS/DAY AVERAGE
7 CT SCANS/DAY AVERAGE
$600 MR SCAN FEE $400 CT SCAN FEE
85% PROJECTED COLLECTION RATE

**********VOLUMES**********

MONTH	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL/AVG
MR SCANS/DAY				10	11	12	13	13	13	13	13	13	12
MR SCANS/MONTH				200	220	240	260	260	260	260	260	260	2220
CT SCANS/DAY										6	7	8	7
CT SCANS/MONTH										120	140	160	420

**********INCOME STATEMENT**********

CASH RECEIPTS	5100	16830	71502	100878	119748	128316	133620	139468	161772	877234
LESS: EXPENSES	-108508	-101452	-101652	-102690	-102690	-102690	-69543	-70243	-76594	-836062
NET INCOME	-103408	-84622	-30150	-1812	17058	25626	64077	69225	85178	41172

**********CASH FLOW SUMMARY**********

BEGINNING CASH BALANCE		196593	111971	81820	80008	97066	122692	190769	263994	
CASH CONTRIBUTIONS	300000									300000
LOAN PROCEEDS						150000	100000			250000
FURNITURE/FIXTURES						-150000	-100000			-250000
PRINCIPAL PAYDOWN									-3110	-3110
AMORTIZATION & DEP'N							4000	4000	4000	12000
NET INCOME	-103408	-84622	-30150	-1812	17058	25626	64077	69225	85178	41172
CASH TO INVESTORS										
ENDING CASH BALANCE	196593	111971	81820	80008	97066	122692	190769	263994	350062	

[NASH6CL]

NASHVILLE

1988 OPERATIONAL EXPENSES

MONTH	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
MR SCANS/MONTH				200	220	240	260	260	260	260	260	260	2220
CT SCANS/MONTH										120	140	160	420
LINENS				248	273	298	322	322	322	471	496	521	3274
FILM & FILM SUPPLIES				1860	2046	2232	2418	2418	2418	3534	3720	3906	24552
CHEMICAL/PROCESSING				338	372	406	439	439	439	642	676	710	4462
OFFICE & MISCELLANEOUS				8000	1368	1493	1617	1617	1617	2364	2488	2612	23177
BILLING				1600	1760	1920	2080	2080	2080	3040	3200	3360	21120
MEDICATION				210	231	252	273	273	273	399	420	441	2772
MED/SURGICAL SUPPLIES				1504	1654	1805	1955	1955	1955	2858	3008	3158	19853
HOUSEKEEPING				300	300	300	300	300	300	300	300	300	2700
INSURANCE				2500	2500	2500	2500	2500	2500	2500	2500	2500	22500
UTILITIES				1700	1700	1700	1700	1700	1700	1700	1700	1700	15300
TELEPHONE				750	750	750	750	750	750	750	750	750	6750
LEGAL & ACCOUNTING				1000	1000	1000	1000	1000	1000	1000	1000	1000	9000
MEDICAL ADVISORY BOARD				600	600	600	600	600	600	600	600	600	5400
TECHNICAL TRAINING				250	250	250	250	250	250	250	250	250	2250
MARKETING													
TAXES				1200	1200	1200	1200	1200	1200	1200	1200	1200	10800
CRYOGENS										6650	6650	6650	19950
CONTINGENCY				5000	4000	3500	3500	3500	3500	3500	3500	3500	33500
AMORTIZATION & DEP'N										4000	4000	4000	12000
FURNITURE/FIXTURES												5650	5650
SYSTEM LEASE													
MOBILE MR LEASE				52500	52500	52500	52500	52500	52500				315000
FACILITY LEASE				3500	3500	3500	3500	3500	3500	8000	8000	8000	45000
TOTAL OPERATING EXPENSE				83060	76004	76205	76905	76905	76905	43758	44458	50809	605009
MANAGER				3500	3500	3500	3500	3500	3500	3500	3500	3500	31500
HEAD TECHNICIAN				3000	3000	3000	3000	3000	3000	3000	3000	3000	27000
TECHNICIANS 2 THRU 5				9100	9100	9100	9100	9100	9100	9100	9100	9100	81900
RECEPT, SEC'Y, CLERKS				3250	3250	3250	3500	3500	3500	3500	3500	3500	30750
FRINGES (@ 35%)				6598	6598	6598	6685	6685	6685	6685	6685	6685	59903
TOTAL SALARY EXPENSE				25448	25448	25448	25785	25785	25785	25785	25785	25785	231053
TOTAL EXPENSES				108508	101452	101652	102690	102690	102690	69543	70243	76594	836062

1988 - 1989 OPERATION

$600 MR TECHNICAL FEE (1988) $400 CT TECHNICAL FEE (1988)
$600 MR TECHNICAL FEE (1989) $400 CT TECHNICAL FEE (1989)
85% PROJECTED COLLECTION RATE

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
R SCANS/MONTH				200	220	240	260	260	260	260	260	260	2220
T SCANS/MONTH										120	140	160	420
1988 MR CASH RECEIPTS				5100	16830	71502	100878	119748	128316	131580	132600	132600	839154
1988 CT CASH RECEIPTS										2040	6868	29172	38080
R SCANS/MONTH	260	260	260	260	260	260	260	260	260	260	260	260	3120
T SCANS/MONTH	160	160	160	160	160	160	160	160	160	160	160	160	1920
1989 MR CASH RECEIPTS	132600	132600	132600	132600	132600	132600	132600	132600	132600	132600	132600	132600	1591200
1989 CT CASH RECEIPTS	42432	51544	53720	54400	54400	54400	54400	54400	54400	54400	54400	54400	637296
ECEIPTS BREAKDOWN		5%	11%	52%	22%	10%							
MONTH		1	2	3	4	5							

\SHVILLE

1989 SECOND YEAR OF OPERATION
13 MR SCANS/DAY AVERAGE
8 CT SCANS/DAY AVERAGE
$600 MR SCAN FEE $400 CT SCAN FEE
85% PROJECTED COLLECTION RATE

**********VOLUMES**********

)NTH	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL/AVG
R SCANS/DAY	13	13	13	13	13	13	13	13	13	13	13	13	13
R SCANS/MONTH	260	260	260	260	260	260	260	260	260	260	260	260	3120
T SCANS/DAY	8	8	8	8	8	8	8	8	8	8	8	8	8
T SCANS/MONTH	160	160	160	160	160	160	160	160	160	160	160	160	1920

**********INCOME STATEMENT**********

\SH RECEIPTS	175032	184144	186320	187000	187000	187000	187000	187000	187000	187000	187000	187000	2228496
ESS: EXPENSES	-318884	-138884	-138884	-138884	-138884	-140884	-140884	-140884	-140884	-167884	-167034	-167034	-1939906
CT INCOME	-143852	45260	47436	48116	48116	46116	46116	46116	46116	19116	19966	19966	288590

**********CASH FLOW SUMMARY**********

EGINNING CASH BALANCE	350062	200000	200000	200000	200000	200000	200000	200000	200000	200000	200000	200000	
RINCIPAL PAYDOWN	-3141	-3173	-3205	-3237	-3269	-3302	-3335	-3368	-3402	-3436	-3470	-3505	-39841
IORTIZATION & DEP'N	4000	4000	4000	4000	4000	6000	6000	6000	6000	6000	6000	6000	62000
CT INCOME	-143852	45260	47436	48116	48116	46116	46116	46116	46116	19116	19966	19966	288590
\SH TO INVESTORS	-7069	-46087	-48232	-48746	-24424	-24407	-24391	-24374	-24357	-10840	-11248	-11231	-305406
EPAY DEVELOPMENT COSTS				-134	-24424	-24407	-24391	-24374	-24357	-10840	-11248	-5825	-150000
EPAY MARKETING COSTS												-5406	-5406
NDING CASH BALANCE	200000	200000	200000	200000	200000	200000	200000	200000	200000	200000	200000	200000	

NASHVILLE

1989 OPERATIONAL EXPENSES

MONTH	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
MR SCANS/MONTH	260	260	260	260	260	260	260	260	260	260	260	260	3120
CT SCANS/MONTH	160	160	160	160	160	160	160	160	160	160	160	160	1920
LINEN	521	521	521	521	521	521	521	521	521	521	521	521	6250
FILM & FILM SUPPLIES	3906	3906	3906	3906	3906	3906	3906	3906	3906	3906	3906	3906	46872
CHEMICAL/PROCESSING	710	710	710	710	710	710	710	710	710	710	710	710	8518
OFFICE & MISCELLANEOUS	2612	2612	2612	2612	2612	2612	2612	2612	2612	2612	2612	2612	31349
BILLING	3360	3360	3360	3360	3360	3360	3360	3360	3360	3360	3360	3360	40320
MEDICATION	441	441	441	441	441	441	441	441	441	441	441	441	5292
MED/SURGICAL SUPPLIES	3158	3158	3158	3158	3158	3158	3158	3158	3158	3158	3158	3158	37901
VARIABLE EXPENSES	14708	14708	14708	14708	14708	14708	14708	14708	14708	14708	14708	14708	176501
HOUSEKEEPING	300	300	300	300	300	300	300	300	300	300	260	260	3520
INSURANCE	2500	2500	2500	2500	2500	2500	2500	2500	2500	2500	2600	2600	30200
UTILITIES	2000	2000	2000	2000	2000	2000	2000	2000	2000	2000	1040	1040	22080
TELEPHONE	1000	1000	1000	1000	1000	1000	1000	1000	1000	1000	1000	1000	12000
LEGAL & ACCOUNTING	1000	1000	1000	1000	1000	1000	1000	1000	1000	1000	1040	1040	12080
MEDICAL ADVISORY BOARD	600	600	600	600	600	600	600	600	600	600	600	600	7200
TECHNICAL TRAINING	250	250	250	250	250	250	250	250	250	250	260	260	3020
MARKETING	1000	1000	1000	1000	1000	1000	1000	1000	1000	1000	1000	1000	12000
TAXES	1200	1200	1200	1200	1200	1200	1200	1200	1200	1200	1200	1200	14400
MAINTENANCE										19000	19000	19000	57000
EQUIPMENT UPGRADES										8000	8000	8000	24000
CRYOGENS	6650	6650	6650	6650	6650	6650	6650	6650	6650	6650	6650	6650	79800
CONTINGENCY	1000	1000	1000	1000	1000	1000	1000	1000	1000	1000	1000	1000	12000
AMORTIZATION & DEP'N	4000	4000	4000	4000	4000	6000	6000	6000	6000	6000	6000	6000	62000
FURNITURE/FIXTURES	5650	5650	5650	5650	5650	5650	5650	5650	5650	5650	5650	5650	67805
SYSTEM LEASE	240000	60000	60000	60000	60000	60000	60000	60000	60000	60000	60000	60000	900000
FACILITY LEASE	8000	8000	8000	8000	8000	8000	8000	8000	8000	8000	8000	8000	96000
OPERATING EXPENSE	289859	109859	109859	109859	109859	111859	111859	111859	111859	138859	138009	138009	1591606
MANAGER	4000	4000	4000	4000	4000	4000	4000	4000	4000	4000	4000	4000	48000
TECHNICIANS	14000	14000	14000	14000	14000	14000	14000	14000	14000	14000	14000	14000	168000
RECEPT, SEC'Y, CLERKS	3500	3500	3500	3500	3500	3500	3500	3500	3500	3500	3500	3500	42000
FRINGES (@ 35%)	7525	7525	7525	7525	7525	7525	7525	7525	7525	7525	7525	7525	90300
TOTAL SALARY & FRINGES	29025	29025	29025	29025	29025	29025	29025	29025	29025	29025	29025	29025	348300
TOTAL EXPENSES	318884	138884	138884	138884	138884	140884	140884	140884	140884	167884	167034	167034	1939906

IVE-YEAR PURCHASE PAYMENT SCHEDULE: MAXIMUM PRINCIPAL 254015 INTEREST 12.0% MONTHS 60

98C		JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
	PRINCIPAL PAYMENT												3110	3110
	INTEREST PAYMENT										1500	2515	2540	6555
	LOAN PAYMENT									-150000	-100000		5650	-244350
	PRINCIPAL BALANCE									150000	251500	254015	250905	
989														
	PRINCIPAL PAYMENT	3141	3173	3205	3237	3269	3302	3335	3368	3402	3436	3470	3505	39841
	INTEREST PAYMENT	2509	2478	2446	2414	2381	2349	2316	2282	2249	2215	2180	2146	27965
	LOAN PAYMENT	5650	5650	5650	5650	5650	5650	5650	5650	5650	5650	5650	5650	67805
	PRINCIPAL BALANCE	247763	244591	241386	238149	234881	231579	228244	224876	221475	218039	214569	211064	
990														
	PRINCIPAL PAYMENT	3540	3575	3611	3647	3684	3720	3758	3795	3833	3871	3910	3949	44893
	INTEREST PAYMENT	2111	2075	2039	2003	1967	1930	1893	1855	1817	1779	1740	1701	22912
	LOAN PAYMENT	5650	5650	5650	5650	5650	5650	5650	5650	5650	5650	5650	5650	67805
	PRINCIPAL BALANCE	207524	203949	200338	196691	193008	189287	185530	181735	177902	174030	170120	166171	
991														
	PRINCIPAL PAYMENT	3989	4029	4069	4110	4151	4192	4234	4276	4319	4362	4406	4450	50587
	INTEREST PAYMENT	1662	1622	1582	1541	1500	1458	1416	1374	1331	1288	1244	1200	17218
	LOAN PAYMENT	5650	5650	5650	5650	5650	5650	5650	5650	5650	5650	5650	5650	67805
	PRINCIPAL BALANCE	162182	158154	154085	149975	145824	141632	137398	133122	128803	124440	120034	115584	
992														
	PRINCIPAL PAYMENT	4495	4540	4585	4631	4677	4724	4771	4819	4867	4916	4965	5014	57003
	INTEREST PAYMENT	1156	1111	1065	1020	973	927	879	832	783	735	686	636	10803
	LOAN PAYMENT	5650	5650	5650	5650	5650	5650	5650	5650	5650	5650	5650	5650	67805
	PRINCIPAL BALANCE	111089	106550	101965	97334	92657	87933	83162	78343	73476	68561	63596	58581	
993														
	PRINCIPAL PAYMENT	5065	5115	5166	5218	5270	5323	5376	5430	5484	5539	5594		58581
	INTEREST PAYMENT	586	535	484	432	380	327	274	220	166	111	56		3573
	LOAN PAYMENT	5650	5650	5650	5650	5650	5650	5650	5650	5650	5650	5650		62155
	PRINCIPAL BALANCE	53517	48402	43235	38017	32747	27424	22048	16618	11134	5594	0		

NASHVILLE

CASH DISTRIBUTION AND INTERNAL RATE OF RETURN CALCULATIONS

		1988	1989	1990	1991	1992	1993		
A. TOTAL LP CASH CONTRIBUTIONS		297000							
GP CAPITAL CONTRIBUTION		3000							
TOTAL CASH CONTRIBUTION		300000							
B. UNRECOVERED CAPITAL		300000							
LESS: RECOVERED CAPITAL			-300000						
ENDING UNRECOVERED CAPITAL		300000							
C. TOTAL CASH DISTRIBUTION			305406	422297	635388	742968	735039		
C. DIVISION OF RECOVERED CAPITAL:									
TO LIMITED PARTNERS	99%		302352	418074	629034	735538	727689		
TO GENERAL PARTNER	1%		3054	4223	6354	7430	7350		
D. PRE-TAX INTERNAL RATE OF RETURN (IRR):								INTERNAL RATE OF RETURN ESTIMATE	ACTUAL
TO LIMITED PARTNERS		-297000	302352	418074	629034	735538	727689	4.00	78%
TO GENERAL PARTNER		-3000	3054	4223	6354	7430	7350	4.00	78%

APPENDIX C

AGREEMENT

OF

LIMITED PARTNERSHIP

NASHVILLE IMAGING CENTER, L.P.

LIST OF ATTACHMENTS

1. Report of the Council on Ethical and Judicial Affairs of the American Medical Association
2. Barbara Mishkin's article of 1987 found in the publication Ethics and Medicine entitled "Physicians as Entrepeneurs"
3. Food, Drug and Cosmetic Act, Chapter 21, section 321 (h) (1976)
4. Laws of Arizona, Professions and Occupations, Article 1, section 32-1401, (12.)(ff)
5. California Business and Professions Code, section 654.2 (b)(d)(e) (1986)
6. Code of Virginia, Article 6, General Standards of Practice, section 54.1-2964 (1988)
7. Ethical Practices Board, Conflict of Interest Rules, part 4515.0100, Subpart 5
8. Letters commenting the Proposed Fee Splitting Rules:
   a. Dr. Robert D. Christensen's letter of May 3, 1988
   b. Dr. Robert W. Geist's letter of May 9, 1988
   c. Dr. Peter T. Smyth's letter of June 30, 1988
   d. Dr. Robert H. Rosenberg's letter of July 14, 1988
   e. Dr. Robert E. Nesse's letter of July 19, 1988
   f. Dr. Theodore C. Larson, III's letter of July 25, 1988
   g. Dr. Robert W. Geist's memo of July 26, 1988
   h. Elizabeth W. Harton's letter of August 3, 1988
   i. Jerome B. Connolly's (Physical Therapist) letter of August 17, 1988
   j. Dr. James D. Rusin's letter of September 14, 1988
   k. Millie Snyder's letter of October 5, 1988
   l. Dr. Paul Sander's letter of October 23, 1988 (MMA chairman)
   m. Drs. Lyle Munneki's and Scott M. Jensen's letter of October 14, 1988
   n. Robert Eelkema's letter of November 21, 1988
   o. Todd I. Freeman's letter of March 21, 1989
9. Minnesota Physician, August 1988, Volume 2, No. 5
10. Mr. H. Leonard Boche's memo of July 20, 1988
11. Mr. Marczewski's memo of August 25, 1988
12. Federal Trade Commission documents regarding Fee Splitting submitted by Alan Soudakoff on December , 1988
13. Fee Splitting: An Overview - Handout given at Fee Splitting Forum
14. Minnesota Board of Medical Examiners UPDATE, Spring 1988
15. Board of Medical Examiners Fee Splitting study

FEE SPLITTING STUDY

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Executive Summary....Section 1

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Laws and Rules....Section 3

Replies from Professional Organizations....Section 4

Staff Comments....Section 5

Mailing list....Section 6

EXECUTIVE SUMMARY

The Fee Splitting Study for the Minnesota Board of Medical Examiners commenced with a May 21, 1986 letter from staff to the other 49 states, the District of Columbia, and territories with medical boards. The letter requested of each state, copies of any statutes, rules or policy statements on the subject of fee splitting.

Of the 67 jurisdictions contacted, 33 replied. Their responses are condensed on the enclosed chart, and copies of the laws and rules are also enclosed.

Only 10 states reported no laws or rules on fee splitting; 13 had brief statutes against the practice, similar to Minnesota's current law. More details of each state's handling of fee splitting are addressed in the staff comments section.

In mid-July, a variety of health-related and medical professional organizations were asked for their input on the issue, from their perspectives in the field of health care. A notice was also posted in the state registry. Nine groups responded, expressing issues they feel worthy of consideration by the Board as rules are promulgated. The replies received are enclosed.

Finally, a number of organizations or firms have asked to be included on a mailing list to receive the fee splitting rules. These names and addresses comprise the final section.

FEE SPLITTING SURVEY

STATE	LAW: YES	LAW: NO	RULE: YES	RULE: NO	INFO PER PHONE CALL	SEE ATTACHED COPY: LAW	RULE	LETTER
ALABAMA	X			X				X
ALASKA		X		X				
ARIZONA		X		X				X
CALIFORNIA	X					X		X
COLORADO	X					X		
CONNECTICUT		X		X				X
DELAWARE	X					X		
DISTRICT OF COLUMBIA	X					X		
HAWAII		X		X	X			
ILLINOIS	X		X			X	X	X
INDIANA			X				X	X
IOWA			X				X	
KANSAS	X					X		
KENTUCKY		X		X				X
MARYLAND	X		X			X	X	X
MICHIGAN	X					X		X
MISSOURI	X							X
NEBRASKA	X					X		
NEVADA	X					X		X
NEW HAMPSHIRE		X		X				X
NEW JERSEY			X				X	X

FEE SPLITTING SURVEY

STATE	LAW: YES	LAW: NO	RULE: YES	RULE: NO	INFO PER PHONE CALL	SEE ATTACHED COPY: LAW	SEE ATTACHED COPY: RULE	SEE ATTACHED COPY: LETTER
NEW YORK	X					X		
NORTH DAKOTA		X		X				X
OHIO	X					X		X
OREGON		X		X				X
RHODE ISLAND	X					X		X
SOUTH DAKOTA	X					X		X
TENNESSEE	X		X			X	X	X
VERMONT		X		X	X			
VIRGINIA	X					X		X
WASHINGTON	X					X		X
WISCONSIN	X					X		
WYOMING		X		X				X

§ 650. Consideration for referral of patients, clients, or customers; violations; penalty

Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code the offer, delivery, receipt or acceptance, by any person licensed under this division of any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person, irrespective of any membership, proprietary interest or coownership in or with any person to whom such patients, clients or customers are referred is unlawful.

Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code and in Section 654.1 it shall not be unlawful for any person licensed under this division to refer a person to any laboratory, pharmacy, clinic, or health care facility solely because such licensee has a proprietary interest or coownership in such laboratory, pharmacy, clinic, or health care facility; but such referral shall be unlawful if the prosecutor proves that there was no valid medical need for such referral.

"Health care facility" means a hospital, nursing home, medical care facility, or private mental institution licensed by the State Department of Health Services.

A violation of this section is a public offense and is punishable upon a first conviction by imprisonment in the county jail for not more than one year, or by imprisonment in the state prison, or by a fine not exceeding ten thousand dollars ($10,000), or by both such imprisonment and fine. A second or subsequent conviction is punishable by imprisonment in the state prison.

(Amended by Stats.1975, c. 303, p. 750, § 1; Stats.1977, c. 1252, p. 4287, § 4, operative July 1, 1978; Stats.1981, c. 610, p. 2348, § 1.)

1975 Amendment. Inserted "and in section 654.1" in the second paragraph and substituted "State Department of Health" for "Department of Public Health or the Department of Mental Hygiene" in the third paragraph.

1981 Amendment. Added the final paragraph.

Cross References

Violation as ground for suspension or revocation of professional corporation's certificate, see Corporations Code § 13408.5.

Notes of Decisions

Optometric franchises 5

1. Construction and application

Contract between medical doctor and lay hospital administrator whereby the administrator was to contact fellow hospital administrators on behalf of the medical doctor in an effort to persuade them to contract for their emergency room services with the medical doctor and under which the administrator was to receive $250 per month for each hospital client successfully referred by administrator was void in that it violated this section, inasmuch as the referred hospitals became the "clients" or "customers" of the medical doctor and, in turn, the emergency room patients of the hospitals contracted with became referred "patients." Matson v. Hosta (App. 2 Dist.1984) 199 Cal.Rptr. 859, 152 C.A.3d 980.

Physicians may refer patients to clinical laboratories in which they have limited partnership interests without violating Bus. & Prof.C. § 650, if appropriate disclosures are made to patients, valid medical need exists for referral, and physicians' return on investment is not measured by number or value of their referrals. 68 Ops.Atty.Gen. 28, 2-8-85.

The operation of a dental referral is prohibited by this section, but not by §§ 651, 1680 or 1701 dealing with false advertising, solicitation or practice of dentistry under a false or fictitious name. 65 Ops.Atty.Gen. 252, 4-23-82.

The provision of "professional courtesy services" by clinical laboratories to a physician or his family or to his physician-patients or their families violates this section only where such services are provided as compensation or inducement for referring patients to the clinical laboratory. 63 Ops.Atty.Gen. 89, 2-8-80.

5. Optometric franchises

For a particularly described optometric franchise to legally operate under California law the franchisor would have to be registered with the state board of optometry as a licensed optometrist or a licensed professional optometric corporation, but the restrictions on the number of offices such licensees could legally maintain would severely impair the utility of any franchise operation. 45 Ops.Atty.Gen. 366, 6-10-65.

§ 650.1. Lease or rental arrangement between pharmacy and hospital or person licensed to practice under medical practice act; prohibitions; arrangements deemed to be in compliance; enforcement

(a) Any amount payable to any hospital, as defined in Section 4047, or any person or corporation prohibited from pharmacy permit ownership by subdivision (a) of Section 4080.5 under any rental, lease or service arrangement with respect to the furnishing or supply of pharmaceutical services and products, which is determined as a percentage, fraction, or portion of (1) the charges to patients or of

(2) any measure of hospi
services is prohibited.

(b) Any lease or rental
compliance with subdivisi

(c) Any lease or rental
effective date of this se
expiration or the expiratio
provided that the lease or
amounts not in excess of

(d) The California State
Department of Health Se
person * * * as is necessar
of the respective regulator
section. Violations of this
lessor, and shall be grounc

(Added by Stats.1980, c. 4

Library References

Drugs and Narcotics ⇐12.
C.J.S. Drugs and Narcotics §§

§ 650.2. Group advertisi

Notwithstanding the pro
unlawful for a person licens
any other person, to particip
long as:

(a) The patient referrals
ing.

(b) The service advertises

(c) The service does not e

(d) The service does not
referrals or amount of profe

(e) Participating dentists
referred.

(f) The service registers w
address.

(g) The service files with t
contract that regulates its rel
not open to public inspection

The Board of Dental Exa
administer this section.

The Board of Dental Exami
issuance of an injunction re

It is unlawful and shall con
referral service for dentists
Examiners of California.

It is the intent of the Legis
provided in Section 650. The
purposes of advertising.

This section shall not be c
engage in the practice of dent

(Added by Stats.1983, c. 1061,

Asterisks * * * indicate deleti

laboratory licensed under Section 1265 in which the licensee has any membership, proprietary interest, or coownership in any form, or has any profit-sharing arrangement, unless the licensee at the time of making such referral discloses in writing such interest to the patient, client, or customer. * * * The written disclosure shall indicate that the patient may choose any clinical laboratory for purposes of having any laboratory work or assignment performed.

This section shall not apply to persons who are members of a medical group which contracts to provide medical care to members of a group practice prepayment plan registered under the Knox-Keene Health Care Service Act of 1975, Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

This section shall not apply to any referral to a clinical laboratory which is owned and operated by a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

This section does not prohibit the acceptance of evaluation specimens for proficiency testing or referral of specimens or such assignment from one clinical laboratory to another clinical laboratory, either licensed or exempt under this chapter, providing the report indicates clearly the laboratory performing the test.

"Proprietary interest" does not include ownership of a building where space is leased to a clinical laboratory at the prevailing rate under a straight lease arrangement.

A violation of this section is a public offense and is punishable upon a first conviction by imprisonment in the county jail for not more than one year, or by imprisonment in the state prison, or by a fine not exceeding ten thousand dollars ($10,000), or by both such imprisonment and fine. A second or subsequent conviction shall be punishable by imprisonment in the state prison.

(Added by Stats.1975, c. 303, p. 751, § 2. Amended by Stats.1978, c. 1161, p. 3502, § 17; Stats.1981, c. 610, p. 2348, § 2.)

1978 Amendment. Substituted, in the second paragraph "Knox-Keene Health Care Service Act of 1975, Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code" for "Knox-Mills Health Plan Act."

1981 Amendment. Substituted in the second sentence of the first paragraph "The written disclosure" for "Such written disclosure" and added the sixth paragraph.

Library References

Physicians and Surgeons ⇐10.
C.J.S. Physicians and Surgeons §§ 31 to 35.

§ 654.2. Prohibited charges, billings, solicitations, or referrals; disclosure of beneficial interest; sign or written statement; definitions; application of section

(a) It is unlawful for any person licensed under this division or under any initiative act referred to in this division to charge, bill, or otherwise solicit payment from a patient on behalf of, or refer a patient to, an organization in which the licensee, or the licensee's immediate family, has a significant beneficial interest, unless the licensee first discloses in writing to the patient that there is such an interest and advises the patient that * * * the patient may choose any organization for the purpose of obtaining the services ordered or requested by the licensee.

(b) The disclosure requirements of subdivision (a) may be met by posting a conspicuous sign in an area which is likely to be seen by all patients who use the facility or by providing those patients with a written disclosure statement. Where referrals, billings, or other solicitations are between licensees who contract with multispecialty clinics pursuant to subdivision (1) of Section 1206 of the Health and Safety Code or who conduct their practice as members of the same professional corporation or partnership, and the services are rendered on the same physical premises, or under the same professional corporation or partnership name, the requirements of subdivision (a) may be met by posting a conspicuous disclosure statement at a single location which is a common area or registration area or by providing those patients with a written disclosure statement. * * *

(c) For the purposes of this section, the following terms have the following meanings:

(1) "Immediate family" includes the spouse and children of the licensee, the parents of the licensee and licensee's spouse, and the spouses of the children of the licensee.

(2) "Significant beneficial interest" means any financial interest that is equal to or greater than the lesser of the following:

(A) Five percent of the whole.

Asterisks * * * indicate deletions by amendment

(B) Five thousand dollars ($5,000).

(d) This section shall not apply to a "significant beneficial interest" which is limited to ownership of a building where the space is leased to the organization at the prevailing rate under a straight lease agreement or to any interest held in publicly traded stocks.

(e)(1) This section does not prohibit the acceptance of evaluation specimens for proficiency testing or referral of specimens or assignment from one clinical laboratory to another clinical laboratory, either licensed or exempt under this chapter, if the report indicates clearly the name of the laboratory performing the test.

(2) This section shall not apply to relationships governed by other provisions of this article nor is this section to be construed as permitting relationships or interests that are prohibited by existing law on the effective date of this section.

(3) The disclosure requirements of this section shall not be required to be given to any patient, customer, or his or her representative, if the licensee, organization, or entity is providing or arranging for health care services pursuant to a prepaid capitated contract with the State Department of Health Services.

(Added by Stats.1984, c. 639, p. —, § 1. Amended by Stats.1985, c. 1542, p. ——, § 1.)

§ 655. Prohibited arrangements between optometrists and registered dispensing opticians or suppliers of optometric appliances or devices

(a) No person licensed under Chapter 7 (commencing with Section 3000) of this division may have any membership, proprietary interest, coownership, landlord-tenant relationship, or any profit-sharing arrangement in any form, directly or indirectly, * * * with any person licensed under Chapter 5.5 (commencing with Section 2550) of this division * * *.

* * * (b) No person licensed under Chapter 5.5 (commencing with Section 2550) of this division may have any membership, proprietary interest, coownership, landlord-tenant relationship, or any profit sharing arrangement in any form directly or indirectly with any person licensed under Chapter 7 (commencing with Section 3000) of this division * * *.

* * * (c) No person licensed under Chapter 7 (commencing with Section 3000) of this division may have any membership, proprietary interest, coownership, landlord-tenant relationship, or any profit-sharing arrangement in any form, directly or indirectly, either by stock ownership, interlocking directors, trusteeship, mortgage, trust deed, or otherwise with any person who is engaged in the manufacture, sale, or distribution to physicians and surgeons, optometrists, or dispensing opticians of lenses, frames, optical supplies, optometric appliances or devices or kindred products.

Any violation of this section constitutes a misdemeanor as to such person licensed under Chapter 7 (commencing with Section 3000) of this division and as to any and all persons, whether or not so licensed under this division, who participate with such licensed person in a violation of any provision of this section.

(Amended by Stats.1979, c. 975, p. 3339, § 1, operative Jan. 1, 1983.)

1979 Amendment. Rewrote the former first two paragraphs to form subds. (a) to (c).

Section 3 of Stats.1979, c. 975, provided:

"This act shall become operative January 1, 1983."

Notes of Decisions

1. In general

Franchises offered to optometrists by manufacturer of ophthalmic products were violative of this section and §§ 2543, 3041, 3042 prohibiting practices of dispensing opticians, optometrists, and optical suppliers, in view of substantial control exercised under franchise agreements, contrary to public policy, by manufacturer over optometrists, including requirements relating to design specifications of optometrists' offices, financing of practices, and stocking of only manufacturer's approved frames, lenses, and other optical goods and supplies. California Ass'n of Dispensing Opticians v. Pearle Vision Center, Inc. (1983) 191 Cal.Rptr. 762, 143 C.A.3d 419.

When operative on January 1, 1983, the amended version of this section will prohibit an optician from leasing adjoining business office spaces from the landlord and later unconditionally assigning the lease on one of them to an optometrist, and with regard to the office space so assigned, a clause in the original lease with the landlord providing the optician the right of first refusal to lease that business office on default or vacation by the optometrist would also violate this section; in addition, the amended version will apply to all such business lease and sub-lease arrangements that may exist between opticians and optometrists on January 1, 1983. 64 Ops.Atty.Gen. 192, 3-4-81.

§ 655.1. Repealed by Stat

The repealed section, added by 6299, § 1, providing for a study to commercial practice restrictions in

§ 655.2. Employment of h

No physician and surgeon Section 2000), nor any audi individual licensed pursuant t or selling hearing aids.

This section shall not appl with or is affiliated with a con the Knox-Keene Health Car Division 2 of the Health and

(Added by Stats.1979, c. 970,

Library References

Physicians and Surgeons ⇐6(1).
C.J.S. Physicians and Surgeons §§

§ 655.5. Charge, bill or sol penalty

It is unlawful for any perso this division or for any clinic patient, client or customer for clinical laboratory or under his is apprised at the first time of of the clinical laboratory per solicitation of payment shall laboratory concerned and shall account, bill, or charge.

This section shall not apply with a health care service plan such services are to be provide charge or liability on account t

A violation of this section imprisonment in the county jail by a fine not exceeding ten tho second or subsequent conviction

(Amended by Stats.1978, c. 116

1981 Amendment. Added the final

§ 656. Injunction

Whenever any person has enga or will constitute, a violation of a wherein the acts or practices tak appropriate order, restraining s Board of Medical Quality Assura the Attorney General, or the dist

The proceedings under this sec of Title 7 of Part 2 of the Code

(Amended by Stats.1978, c. 1161,

Regulations, Administrative code, title 16

1348. Trusts.

The restrictions on the ownership of the shares of professional corporations shall apply to both the legal and equitable title to such shares.

NOTE: Authority cited: Sections 2018 and 2412, Business and Professions Code. Reference: Sections 13406 and 13407, Business and Professions Code.

HISTORY:

1. Amendment filed 8-5-81; effective thirtieth day thereafter (Register 81, No. 32)

1349. Partnerships.

Nothing in Section 2416 of the code or this article shall be construed to authorize a partnership agreement in which fees are combined or shared between a physician and surgeon(s) and a podiatrist(s) or any other licensed professional, not a physician and surgeon.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Sections 2285, 2415 and 17500, Business and Professions Code.

HISTORY:

1. Renumbering of former Section 1350.4 to Section 1349 filed 9-21-83; effective thirtieth day thereafter (Register 83, No. 39). For history of former Section 1349, see Register 81, No. 32.

Article 14. Fictitious and Group Names

1350. Application.

(a) Applications for a fictitious name permit shall be submitted on a form provided by the division containing such information as is required therein.

(b) The application shall be signed by a licensed person who is a member of the group or clinic or by an officer of the professional corporation, as the case may be, requesting the use of such name.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Sections 2285 and 2415, Business and Professions Code.

HISTORY:

1. Repealer of former Section 1350 and renumbering of former Section 1350.1 to Section 1350 filed 9-21-83; effective thirtieth day thereafter (Register 83, No. 39). For prior history, see Registers 81, No. 32 and 79, No. 23.

1350.2. Approval and Issuance of Permits.

(a) The division shall within a reasonable time after an application has been filed issue a fictitious name permit or refuse to approve the application and notify the applicant of the reasons therefor.

(b) All fictitious name permits shall be issued and made effective after review and approval of the application by the division; provided that, for good cause shown, the division may issue a permit retroactively effective the date on which the application and/or initial permit fee are filed, whichever last occurs. A fictitious name permit shall be dated when it is issued and made effective.

(c) No licensed person shall render professional services using a fictitious, false or assumed name or any name other than his or her own unless and until a fictitious name permit has been issued by the division.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Sections 2285 and 2415, Business and Professions Code.

HISTORY:

1. New NOTE filed 8-5-81, effective thirtieth day thereafter (Register 81, No. 32)

delinquent for more than two years shall be reinstated unless the applicant demonstrates to the board his continued professional competence.

12-36-124. Certification of licensing. Upon request therefor and the payment of a fee determined pursuant to section 24-34-105, C.R.S., the secretary of the board shall issue its certificate or endorsement with respect to the licensing of, and the official record of the board relating to, any licensee to whom a license to practice medicine in this state has been issued by this or any prior board; and, upon request therefor and the payment of a fee determined pursuant to section 24-34-105, C.R.S., the secretary shall issue a certificate evidencing that any such licensee is duly licensed to practice medicine in this state.

12-36-125. Division of fees - independent advertising or marketing agent. (1) (a) If any person holding a license issued by the board or by the state board of medical examiners as constituted under any prior law of this state divides any fee or compensation received or charged for services rendered by him as such licensee or agrees to divide any such fee or compensation with any person, firm, association, or corporation as pay or compensation to such other person for sending or bringing any patient or other person to such licensee, or for recommending such licensee to any person, or for being instrumental in any manner in causing any person to engage such licensee in his professional capacity; or if any such licensee shall either directly or indirectly pay or compensate or agree to pay or compensate any person, firm, association, or corporation for sending or bringing any patient or other person to such licensee for examination or treatment, or for recommending such licensee to any person, or for being instrumental in causing any person to engage such licensee in his professional capacity; or if any such licensee, in his professional capacity and in his own name or behalf, shall make or present a bill or request a payment for services rendered by any person other than the licensee, such licensee commits a class 3 misdemeanor and shall be punished as provided in section 18-1-106, C.R.S.

(b) Notwithstanding the provisions of paragraph (a) of subsection (1) of this section, a licensee may pay an independent advertising or marketing agent compensation for the advertising or marketing services rendered on the licensee's behalf by such agent, including compensation which is paid for the results or performance of such services on a per patient basis.

(c) As used in this subsection (1), "independent advertising or marketing agent" means a person, firm, association, or corporation which performs advertising or other marketing services on behalf of licensees, including referrals of patients to licensees resulting from

patient-initiated responses to such advertising or marketing services.

(2) Violation of the provisions of this section shall constitute grounds for the suspension or revocation of a license to practice medicine or the placing of the holder thereof on probation.

(3) The board shall not have the authority to regulate, directly or indirectly, advertising or marketing activities of independent advertising or marketing agents except as provided in this section. The board may, in the name of the people of the state of Colorado, apply for an injunction in the district court to enjoin any independent advertising or marketing agent from the use of advertising or marketing which the court finds on the basis of the evidence presented by the board to be misleading, deceptive, or false; except that a licensee shall not be subject to discipline by the board, injunction, or prosecution in the court under this article or any other law for advertising or marketing by an independent advertising or marketing agent if the factual information which the licensee provides to the advertising or marketing agent is accurate and not misleading, deceptive, or false.

12-36-126. Recovery of fees illegally paid. If any licensee, in violation of section 12-36-125, divides or agrees to divide any fee or compensation received by him for services rendered in his professional capacity with any person whomsoever, the person who has paid such fee or compensation to such licensee may recover the amount unlawfully paid or agreed to be paid from either the licensee or from the person to whom such fee or compensation has been paid, by an action to be instituted within two years from the date on which such fee or compensation was so divided or agreed to be divided.

12-36-127. Liability of persons other than licensee. If any person, firm, association, or corporation receives, either directly or indirectly, any pay or compensation given or paid in violation of section 12-36-125, such person, firm, association, or corporation, and the officers and directors thereof, commits a class 3 misdemeanor and shall be punished as provided in section 18-1-106, C.R.S.

12-36-128. Advertising.

Repealed, L. 85, p. 516, section 5, effective May 3, 1985.

12-36-129. Violations - penalties. (1) Except as provided in subsection (2) of this section, if any person, association, or corporation practices medicine within this state without complying with the provisions of this article, or if any person, association, or corporation otherwise violates any provision of this article, such person or any

officer or director of any such association or corporation commits a class 2 misdemeanor and shall be punished as provided in section 18-1-106, C.R.S. and any person committing a second or subsequent offense commits a class 5 felony and shall be punished as provided in section 18-1-105, C.R.S.

(2) Any person who presents as his own the diploma, license, certificate, or credentials of another, or who gives either false or forged evidence of any kind to the board, or any member thereof, in connection with an application for a license to practice medicine, or who practices medicine under a false or assumed name, or who falsely impersonates another licensee of a like or different name commits a class 5 felony and shall be punished as provided in section 18-1-105, C.R.S.

(3) No action may be maintained against an individual who has been the recipient of services constituting the unlawful practice of medicine for the breach of a contract involving the unlawful practice of medicine or the recovery of compensation for services rendered under such a contract.

(4) When an individual has been the recipient of services constituting the unlawful practice of medicine, whether or not he knew that the rendition of the services was unlawful:

(a) He or his personal representative is entitled to recover the amount of any fee paid for the services; and

(b) He or his personal representative may also recover a reasonable attorney fee as fixed by the court, to be taxed as part of the costs of the action.

12-36-130. Moneys collected.

Repealed, L. 79, p. 525, section 31, effective July 1, 1979.

12-36-131. Existing licenses. (1) Nothing in this article shall be construed to invalidate or affect the license of any person holding a valid, unrevoked, and unsuspended license to practice medicine in this state on July 1, 1951, except as otherwise provided by this article.

(2) Nothing in this article shall be construed to invalidate the license of any person holding a valid, unrevoked, and unsuspended license on June 30, 1979, to practice medicine in this state or to affect any disciplinary proceeding or appeal pending on June 30, 1979, or any appointment to the board, the inquiry panel, or the hearings panel made on or before June 30, 1979.

12-36-132. Injunctive proceedings. (1) The board may,

ALABAMA STATE BOARD OF MEDICAL EXAMINERS
OFFICE OF THE GENERAL COUNSEL
WENDELL R. MORGAN, GENERAL COUNSEL

P.O. Box 946
MONTGOMERY, ALABAMA 36102-0946

TELEPHONE
(205) 261-4116
(800) 392-5668

June 6, 1986

Richard L. Auld
Assistant Executive Director
Minnesota Board of Medical Examiners
Suite 106
2700 University Avenue West
St. Paul, MN 55114-1080

Dear Mr. Auld:

This letter is in reference to your May 21, 1986 request for information on administrative rules on fee splitting.

Alabama law provides as a grounds for the suspension or revocation of a license to practice medicine "division of fees or agreement to split or divide the fees received for professional services with any person for bringing or referring a patient". Neither the State Board of Medical Examiners which is responsible for investigation of violations of the Medical Practice Act nor the Medical Licensure Commission which is the adjudicative body which hears and decides complaints has promulgated any rules or regulations attempting to further define fee splitting.

I hope that the foregoing information will be of assistance to you.

Yours sincerely,

Wendell R. Morgan
General Counsel

WRM:baw

cc: Larry Dixon, Executive Director

Hopefully, the above will be of some assistance in your study. If you need additional information regarding our statutes, please do not hesitate to contact me at your convenience.

Sincerely,

BOARD OF MEDICAL EXAMINES
STATE OF ARIZONA

Doug Cerf

DOUGLAS N. CERF
Executive Director

DNC/am

THE ARIZONA BOARD OF MEDICAL EXAMINERS

1990 west camelback road, suite 401 • phoenix, arizona 85015

Governor
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Executive Director
Douglas N. Cerf
Assoc. Executive Director
David O. Landrith
Telephone
(602) 255-3751

May 29, 1986

Mr. Richard L. Auld
Assistant Executive Director
Minnesota Board of Medical Examiners
2700 University Avenue West, Suite 106
St. Paul, Minnesota 55144-1080

Re: Fee Splitting Study

Dear Mr. Auld:

The Arizona Board of Medical Examiners is in receipt of your May 21, 1986 letter requesting information concerning fee splitting.

The Arizona Revised Statutes governing the Board's operations do not specifically identify fee splitting as being grounds for unprofessional conduct. However, Medicare and Medicaid regulations indicate that fee splitting is, in and of itself, a violation of Medicare and Medicaid procedures. With this in mind, the Arizona Revised Statutes indicate that unprofessional conduct, including the following acts and whether occurring in this state or elsewhere: (a) Violation of any federal or state laws or rules and regulations applicable to the practice of medicine; (d) Commission of a felony, whether or not involving moral turpitude, or a misdemeanor involving moral turpitude. In either case, conviction by any court of competent jurisdiction or a plea of no contest is conclusive evidence of the commission; (u) Giving or receiving or aiding or abetting the giving or receiving of rebates, either directly or indirectly; (dd) Knowingly failing to disclose to a patient on a form prescribed by the Board which is dated and signed by the patient or guardian acknowledging that the patient or guardian has read and understands that the doctor has a direct pecuniary interest in a separate diagnostic or treatment agency or in non-routine goods or services which the patient is being prescribed and if the prescribed treatment, goods or services are available on a competitive basis. This subdivision does not apply to a referral by one doctor of medicine to another doctor of medicine within a group of doctors of medicine practicing together.

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY GEORGE DEUKMEJIAN, Gover.

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6393

June 3, 1986

Richard L. Auld
Assistant Executive Director
Minnesota Board of Medical Examiners
2700 University Ave. W., Suite 106
St. Paul, MN 55114-1080

RE: Fee Splitting Study

Dear Mr. Auld:

This is in response to your request for information relative to your plans to draft rules on the subject of fee splitting.

California has an anti-kickback statute making it unlawful for a physician to give or receive money or any type of consideration to induce patient referrals (attached is Section 650, Business and Professions Code).

Our Attorney General has previously stated that it is not improper for a hospital and a hospital-based physician (anesthesiologist, radiologist, pathologist) to enter into a contract for fee splitting, so long as the percentage to the hospital approximates fair reimbursement of overhead expenses, equipment, and other expenses provided by the hospital to the independent contractor physician.

Also attached is Section 654.2, Business and Professions Code, making it unlawful for a physician to refer a patient to an organization in which the physician has a significant beneficial interest unless that interest is disclosed to the patient in writing, including the advice that the patient is free to go elsewhere for the same services.

Sincerely,

Foone Louie

Foone Louie
Staff Counsel

FL:klb

Enclosures

STATE OF CONNECTICUT

DEPARTMENT OF HEALTH SERVICES

DIVISION OF MEDICAL QUALITY ASSURANCE

May 29, 1986

Mr. Richard L. Auld
Assistant Executive Director
Minnesota Board of Medical Examiners
Suite 106
2700 University Avenue, West
St. Paul, Minnesota 55114-1080

SUBJECT: Fee Splitting Study

Dear Mr. Auld:

I am writing in response to your inquiry regarding fee splitting among physicians. This Division does not have any regulations governing these activities. Indeed, this Department is prohibited, by statute, from developing any regulations governing "business practices".

If I can provide any additional information or assistance, please feel free to contact me.

Sincerely,

Gary W. DeWitt, Ph.D.
ASSISTANT DIRECTOR
DIVISION OF MEDICAL QUALITY ASSURANCE

GWD:amh

1307Q

566-7398
Phone.

150 Washington Street — Hartford, Connecticut 06106
An Equal Opportunity Employer

B. By Medical Societies

1. Expulsion from the organization.

2. Censure.

SECTION 14 - RENEWAL OF REGISTRATION

Six months after renewal of registration notices have been sent out to physicians, a registered letter is to be sent to those physicians who have not yet paid their renewal fee notifying them that they have thirty (30) days from the date of the letter in which to renew their registration or their certificate to practice medicine will be considered lapsed and they will be treated as a new applicant upon future re-application. Provided, however, that those physicians who have allowed their certificates to practice medicine lapse will not be required to be re-examined. The requirements for licensure which were in effect at the time of original licensure will be applicable to the application for re-licensure.

SECTION 15 - DISHONORABLE OR UNETHICAL CONDUCT (24 Del. C. §1731 (b)(3))

The phrase "dishonorable or unethical conduct likely to deceive, defraud, or harm the public" as used in 24 Del. C. §1731(b)(3) shall include, but not be limited to, the following specific acts:

a. A pattern of performance of unnecessary medical procedures.

b. Exploitation of the doctor/patient privilege for personal gain or sexual gratification.

c. Fraudulent billing for medical services.

d. Intentional falsification of records maintained for controlled substances and non-controlled drugs.

e. Fraudulent advertising.

f. Willfully failing to treat a person under the physician's care who requires such treatment.

g. Intentional release of confidential information gained as a result of the doctor/patient privilege, unless such release was authorized by the patient or required by subpoena.

h. Conviction of a misdemeanor involving moral turpitude.

i. Payment of a fee by a physician to another physician who has referred the patient to him, unless the fee is in proportion to work actually performed by the referring physician.

j. Any other act tending to bring discredit upon the profession.

SECTION 16 - DEFINITION OF DIRECT SUPERVISION OF PHYSICIANS' ASSISTANTS

A. "Supervision" as that term is used in 24 Del. C. §1703(e)(7) is interpreted by the Board of Medical Practice as requiring that the supervising physician be physically present on the premises and immediately available, in person, for consultation and assistance. Provided, however, that nothing in this interpretation shall in any way interfere with currently valid nursing practices.

DISTRICT of COLUMBIA

§ 2-3305.14. Revocation, suspension, or denial of license or privilege; civil penalty; reprimand.

(a) Each board, subject to the right of a hearing as provided by this subchapter, on an affirmative vote of a majority of its members then serving, may take 1 or more of the disciplinary actions provided in subsection (c) of this section against any applicant, licensee, or person permitted by this subchapter to practice the health occupation regulated by the board in the District who:

(1) Fraudulently or deceptively obtains or attempts to obtain a license for an applicant or licensee or for another person;

(2) Fraudulently or deceptively uses a license;

(3) Is disciplined by a licensing or disciplinary authority or convicted or disciplined by a court of any jurisdiction for conduct that would be grounds for disciplinary action under this section;

(4) Has been convicted in any jurisdiction of any crime involving moral turpitude, if the offense bears directly on the fitness of the individual to be licensed;

(5) Is professionally or mentally incompetent or physically incapable;

(6) Is addicted to, or habitually abuses, any narcotic or controlled substance as defined by Chapter 5 of Title 33;

(7) Provides, or attempts to provide, professional services while under the influence of alcohol or while using any narcotic or controlled substance as defined by Chapter 5 of Title 33, or other drug in excess of therapeutic amounts or without valid medical indication;

(8) Willfully makes or files a false report or record in the practice of a health occupation;

(9) Willfully fails to file or record any medical report as required by law, impedes or obstructs the filing or recording of the report, or induces another to fail to file or record the report;

(10) On proper request in accordance with law, fails to provide details of a patient's medical record to a hospital or another health professional licensed under this chapter or under the laws of another jurisdiction;

(11) Willfully makes a misrepresentation in treatment;

(12) Willfully practices a health occupation with an unauthorized person or aids an unauthorized person in the practice of a health occupation;

(13) Submits false statements to collect fees for which services are not provided;

(14) Pays or agrees to pay anything of value to, or to split or divide fees for professional services with, any person for bringing or referring a patient;

(15) Fails to pay a civil fine imposed by a board, other administrative officer, or court;

(16) Willfully breaches a statutory, regulatory, or ethical requirement of confidentiality with respect to a person who is a patient or client of the health professional, unless ordered by a court;

(17) Refuses to provide service to a person in contravention of Chapter 2 of Title 1;

Dist. of Col.

GEORGE R. ARIYOSHI
GOVERNOR

RUSSEL S. NAGATA
DIRECTOR

NOE NOE TOM
LICENSING ADMINISTRATOR

BOARD OF MEDICAL EXAMINERS

STATE OF HAWAII
PROFESSIONAL & VOCATIONAL LICENSING DIVISION
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
P. O. BOX 3469
HONOLULU, HAWAII 96801

June 9, 1986

Minnesota Board of Medical Examiners
Suite 106
2700 University Avenue W.
St. Paul, MN 55114-1080

Attention: Fee Splitting Study

Dear Sir:

In response to Mr. Richards Auld's request dated May 21, 1986, we are transmitting for your information Hawaii Administrative Rules, Chapter 53, Fees Relating to Boards and Commissions. The Department of Commerce and Consumer Affairs is responsible for establishing appropriate fees for application, examination, licensing and the renewal of licenses for all Boards and Commissions that are under the department for administrative purposes. The fees are updated from time to time to reflect a reasonable relation between the revenue derived from fees and the cost or value of services rendered.

I hope this information will be of value in your fee study.

Very truly yours,

John M. Tamashiro
Executive Secretary

Enclosures

STATE OF ILLINOIS
DRE DEPARTMENT OF REGISTRATION AND EDUCATION
320 West Washington—3rd Floor • Springfield, Illinois 62786 • (217) 785-0800
GARY L. CLAYTON—Director

May 28, 1986

Richard L. Auld
Assistant Executive Director
Minnesota Board of Medical Examiners
2700 University Avenue West
St. Paul, Minnesota 55114-1080

Dear Mr. Auld:

Pursuant to your recent request, please find enclosed the Medical Practice Act and rules for the administration of the Medical Practice Act and Medical Disciplinary Board. Our Department does not have any specific statutes or rules pertaining to fee splitting.

If you have any further questions or need additional information, please do not hesitate to contact me.

Very truly yours,

Kathy Campbell Lynch

Kathy Campbell Lynch
Rules Coordinator

KCL/bp
Enclosures

Section 290.60 Grounds for Revocation and Suspension of License

a) Grounds for Disciplinary Action Against Physicians. As set forth in Section 16 of the Act, *the Department may revoke, suspend, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to the license or certificate of any person issued under the Act or under any other Act in this State to practice medicine, to practice the treatment of human ailments in any manner or to practice midwifery upon any of the following grounds:*

1) *Performance of an elective abortion in any place, locale, facility, or institution other than:*

A) *a facility licensed pursuant to the Ambulatory Surgical Treatment Center Act" (Ill. Rev. Stat. 1979, ch. 111½, par. 157-8.1 et. seq.) as heretofore or hereafter amended;*

B) *an institution licensed pursuant to "An Act relating to the inspection, supervision, licensing and regulation of hospitals", approved July 1, 1953 (Ill. Rev. Stat. 1979, ch. 111½, par. 142 et. seq.) as heretofore or hereafter amended; or*

C) *An ambulatory surgical treatment center or hospitalization or care facility maintained by the State or any agency thereof, where such department or agency has authority under law to establish and enforce standards for the ambulatory surgical treatment centers, hospitalization, or care facilities under its management and control; or*

D) *Ambulatory surgical treatment centers, hospitalization or care facilities maintained by the Federal Government; or*

E) *Ambulatory surgical treatment centers, hospitalization or care facilities maintained by any university or college established under the laws of this State and supported principally by public funds raised by taxation;*

2) *Conviction in this or another State of any crime which is a felony under the laws of this State or conviction of a felony in a federal court, unless such person demonstrates to the Department that he has been sufficiently rehabilitated to warrant the public trust;*

3) *Gross or repeated malpractice resulting in serious injury or death of a patient;*

4) *Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public;*

5) *Obtaining a fee, either directly or indirectly, either in money or in the form of anything else of value or in the form of a financial profit as personal compensation, or as compensation, charge, profit or gain for an employer or for any other person or persons on*

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the fraudulent representation that a manifestly incurable condition of sickness, disease or injury of any person can be permanently cured;

6) *Habitual intemperance in the use of rdent spirits, narcotics, or stimulants to such an extent as to incapacitate for performance of professional duties;*

7) *Holding one's self out to treat human ailments under any name other than his own, or the personation of any other physician;*

8) *Employment of fraud, deception or any unlawful means in applying for or securing a license, certificate, or state hospital permit to practice the treatment of human ailments in any manner, to practice midwifery or in passing an examination therefor, or willful and fraudulent violation of the rules and regulations of the Department governing examinations;*

9) *Holding one's self out to treat human ailments by making false statements, or by specifically designating any disease, or group of diseases and making false claims of one's skill, or of the efficacy or value of one's medicine, treatment or remedy therefor;*

10) *Professional connection or association with, or lending one's name to, another for the illegal practice by another of the treatment of human ailments as a business, or professional connection or association with any person, firm, or corporation holding himself, themselves, or itself out in any manner contrary to this Act;*

11) *Revocation or suspension of a medical license in a sister state;*

12) *A violation of any provision of this Act or of the rules and regulations formulated for the administration of this Act;*

13) *Directly or indirectly giving to or receiving from any physician, person, firm or corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered. Nothing contained in this subsection prohibits persons holding valid and current licenses under this Act from practicing medicine in partnership under a partnership agreement or in a corporation authorized by "The Medical Corporation Act", as now or hereafter amended, or as an association authorized by "The Professional Association Act" as now or hereafter amended, from pooling, sharing, dividing or apportioning the fees and monies received by them or by the partnership, corporation or association in accordance with the partnership agreement or the policies of the Board of Directors of the corporation or association. Nothing contained in this subsection shall abrogate the right of 2 or more persons holding valid and current licenses under this Act to receive adequate compensation for concurrently rendering professional services to a patient and divide a fee; provided, the patient has full knowledge of the division, and, provided, that the division is made in proportion to the services performed and responsibility assumed by each.*

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SOS - RULES DIV.

ILLINOIS

(10) The fee to be paid by a registrant for a wall certificate showing his registration shall be the actual cost of producing such certificate.

(11) The fee for a roster of persons registered as physicians in this State shall be the actual cost of producing such a roster.
Amended by P.A. 83-1111, eff. June 6, 1984; amended by P.A. 83-1246, eff. August 6, 1984.

(4430) Exchange of limited license for license to practice medicine.) Section 14.01. A person holding a limited license to practice in a hospital emergency room who satisfies the requirement set forth in subparagraph (d) of paragraph 2 of Section 4 of this Act may, upon application to the Department and presenting evidence that he has satisfied such requirement, without further fee exchange his limited license for a license to practice medicine in all its branches.
Added by Laws 1965, p. 2529, eff. August 4, 1965.

(4432) Lists of licensees--Publication--Disposition.) Section 15a. The Department shall at least annually publish a list of the names and addresses of all licensees who hold licenses under the provisions of this Act, and of all persons whose licenses have been suspended or revoked within one year, together with such other information relative to the enforcement of the provisions of this Act as it may deem of interest to the public. One of such lists shall be mailed to the county clerk in each county of the State and shall be held by the county clerk as a public record. Such lists shall also be mailed by the Department to any person in the State upon request.
Added by Laws 1957, p. 2695, eff. July 11, 1957.

(4433) Revocation or suspension of license, certificate or permit--Probation or other disciplinary action.) Section 16. The Department may revoke, suspend, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to the license, certificate or state hospital permit of any person issued under this Act or under any other Act in this State to practice medicine, to practice the treatment of human ailments in any manner or to practice midwifery, or may refuse to grant a license, certificate or state hospital permit under this Act or may grant a license, certificate or State hospital permit on a probationary status subject to the limitations of the probation, and may cause any license or certificate which has been the subject of formal disciplinary procedure to be marked accordingly on the records of any county clerk upon any of the following grounds:

1. Performance of an elective abortion in any place, locale, facility, or institution other than:

ILLINOIS

(a) a facility licensed pursuant to the "Ambulatory Surgical Treatment Center Act" as heretofore or hereafter amended;

(b) an institution licensed pursuant to "An Act relating to the inspection, supervision, licensing, and regulation of hospitals" approved July 1, 1953, as heretofore or hereafter amended; or

(c) an ambulatory surgical treatment center or hospitalization or care facility maintained by the State or any agency thereof, where such department or agency has authority under law to establish and enforce standards for the ambulatory surgical treatment centers, hospitalization, or care facilities under its management and control; or

(d) Ambulatory surgical treatment centers, hospitalization or care facilities maintained by the Federal Government; or

(e) Ambulatory surgical treatment centers, hospitalization or care facilities maintained by any university or college established under the laws of this State and supported principally by public funds raised by taxation;

2. Performance of an abortion procedure in a wilful and wanton manner on a woman who was not pregnant at the time the abortion procedure was performed;

3. Conviction in this or another State of any crime which is a felony under the laws of this State or conviction of a felony in a federal court, unless such person demonstrates to the Department that he has been sufficiently rehabilitated to warrant the public trust;

4. Gross or repeated malpractice resulting in serious injury or death of a patient;

5. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public;

6. Obtaining a fee, either directly or indirectly, either in money or in the form of anything else of value or in the form of a financial profit as personal compensation, or as compensation, charge, profit or gain for an employer or for any other person or persons, on the fraudulent representation that a manifestly incurable condition of sickness, disease or injury of any person can be permanently cured;

7. Habitual intemperance in the use of ardent spirits, narcotics or stimulants to such an extent as to incapacitate for performance of professional duties;

8. Holding one's self out to treat human ailments under any name other than his own, or the personation of any other physician;

9. Employment of fraud, deception or any unlawful means in applying for or securing a license, certificate, or state hospital permit to practice the treatment of human ailments in any manner, to practice midwifery or in passing an examination therefor, or wilful and fraudulent violation of the rules and regulations of the department governing examinations;

10. Holding one's self out to treat human ailments by making false statements, or by specifically designating any disease, or group of diseases and making false claims of one's skill, or of the efficacy or value of one's medicine, treatment or remedy therefor;

11. Professional connection or association with, or lending one's name to, another for the illegal practice by another of the treatment of human ailments as a business, or professional connection or association with any person, firm, or corporation holding himself, themselves, or itself out in any manner contrary to this Act;

12. Revocation or suspension of a medical license in a sister state;

13. A violation of any provision of this Act or of the rules and regulations formulated for the administration of this Act;

14. Directly or indirectly giving to or receiving from any physician, person, firm or corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered. Nothing contained in this subsection prohibits persons holding valid and current licenses under this Act from practicing medicine in partnership under a partnership agreement or in a corporation authorized by "The Medical Corporation Act", as now or hereafter amended, or as an association authorized by "The Professional Association Act" as now or hereafter amended, or under "The Professional Corporation Act" as now or hereafter amended, or from pooling, sharing, dividing or apportioning the fees and monies received by them or by the partnership, corporation or association in accordance with the partnership agreement or the policies of the Board of Directors of the corporation or association. Nothing contained in this subsection prohibits 2 or more corporations authorized by "The Medical Corporation Act", as now or hereafter amended, from forming a partnership or joint venture of such corporations, and providing medical, surgical and scientific research and knowledge by employees of these corporations if such employees are licensed under this Act, or from pooling, sharing, dividing, or apportioning the fees and monies received by the partnership or joint venture in

accordance with the partnership or joint venture agreement. Nothing contained in this subsection shall abrogate the right of 2 or more persons holding valid and current licenses under this Act to receive adequate compensation for concurrently rendering professional services to a patient and divide a fee; provided, the patient has full knowledge of the division, and, provided, that the division is made in proportion to the services performed and responsibility assumed by each;

15. A finding by the Medical Disciplinary Board that the registrant after having his license placed on probationary status violated the terms of the probation;

16. Abandonment of a patient;

17. The use or prescription for use of narcotics or controlled substances (designated products) in any way other than for therapeutic purposes;

18. Promotion of the sale of drugs, devices, appliances or goods provided for a patient in such manner as to exploit the patient for financial gain of the physician;

19. Offering, undertaking or agreeing to cure or treat disease by a secret method, procedure, treatment or medicine, or the treating, operating or prescribing for any human condition by a method, means or procedure which the licensee refuses to divulge upon demand of the Department of Registration and Education;

20. Immoral conduct in practice as a physician, or repeated acts of gross misconduct;

21. Willfully making or filing false records or reports in his practice as a physician, including, but not limited to, false records to support claims against the medical assistance program of the Department of Public Aid under the Public Aid Code;

22. Willful omission to file or record, or willfully impeding the filing or recording or inducing another person to omit to file or record medical reports as required by law or willfully failing to report an instance of suspected child abuse or neglect as required by the "Abused and Neglected Child Reporting Act", as now or hereafter amended;

23. Solicitation of professional patronage by any corporation, agents or persons, or profiting from those representing themselves to be agents of the licensee;

24. Gross and willful and continued overcharging for professional services, including filing false statement for collection of fees for which services are not rendered, including, but not limited to, filing such false statements

STATE OF INDIANA
ROBERT D. ORR - Governor

Health Professions Bureau
964 North Pennsylvania Street
Indianapolis, Indiana 46204
(317) 232-2960

May 29, 1986

Richard L. Auld
Assistant Executive Director
Minnesota Board of Medical Examiners
2700 University Avenue West
St. Paul, MN 55114-1080

RE: Fee Splitting Regulations

Dear Mr. Auld:

For your convenience I have enclosed the Indiana statute and administrative rules concerning the pratice of medicine in Indiana. Fee splitting is addressed in 844 IAC 5-1-2.

If you need additional information, feel free to contact this office.

Sincerely,

Mary C. Gaughan
Medical Licensing Board Administrator

MCG/cav

Enclosures

(d) For purposes of clarifying the terminology used in IC 25-22.5-6-2.1(b)(7), and for purposes of the standards of professional conduct and competent practice of medicine, the following definitions apply:

(1) "Addict" means a person who is physiologically and/or psychologically dependent upon a drug which is classified as a narcotic, controlled substance or dangerous drug.

(2) "Habitue" means a person who is physiologically and/or psychologically dependent upon any narcotic, drug classified as a narcotic, dangerous drug or controlled substance under Indiana law; or a person who consumes on a regular basis, and without any medically justifiable purpose, a narcotic drug classified as a narcotic, dangerous drug or controlled substance under Indiana law, whether or not such person has developed a physiological or psychological dependence upon such substance.

(3) "Classified as a narcotic" means any substances which is designated as a controlled substance under IC 35-48-1, or IC 25-48-2, or so classified in any subsequent amendment or revision of said statutes.

(4) "Dangerous drug" means any substance which is designated as a controlled substance under IC 35-48-1, or IC 35-48-2, or so classified in any subsequent amendment or revision of said statute.
(Medical Licensing Board of Indiana; 844 IAC 5-1-1; filed Apr 12, 1984, 8:28 am: 7 IR 1522)

844 IAC 5-1-2 Standards of professional conduct

Authority: IC 25-22.5-2-7
Affected: IC 16-4-8; IC 25-22.5-1-1; IC 25-22.5-6-2.1; IC 34-4-12.6-1

Sec. 2. A practitioner in the conduct of his/her practice of medicine or osteopathic medicine shall abide by, and comply with, the following standards of professional conduct: (a) A practitioner shall maintain the confidentiality of all knowledge and information regarding a patient, including, but not limited to, the patient's diagnosis, treatment and prognosis, and of all records relating thereto, about which the practitioner may learn or otherwise be informed during the course of, or as a result of, the patient-practitioner relationship. Information about a patient shall be disclosed by a practitioner when required by law, including, but not limited to, the requirements of IC 34-4-12.6-1 and IC 16-4-8-1, and any amendments thereto, or when authorized by the patient or those repsonsible for the patient's care.

(b) A practitioner shall give a truthful, candid and reasonably complete account of the patient's condition to the patient or to those responsible for the patient's care, except where a practitioner reasonable determines that the information is or would be detrimental to the physical or mental health of the patient, or in the case of a minor or incompetent person, except where a practitioner reasonably determines that the information is or would be detrimental to the physical or mental health of those persons responsible for the patient's care.

(c) The practitioner shall give reasonable written notice to a patient or to those responsible for the patient's care when the practitioner withdraws from a case so that another practitioner may be employed by the patient or by those responsible for the patient's care. A practitioner shall not abandon a patient.

A practitioner who withdraws from a case, except in emergency circumstances, shall, upon written request, and in conformity with the provisions of IC 16-4-8-1 through IC 16-4-8-11, and of any subsequent amendment or revision thereof, make available to his/her patient or to those responsible for the patient's care, and to any other practitioner or specific professional health care provider employed by the patient, or by those responsible for the patient's care, all records, test results, histories, x-rays, radiographic studies, diagnoses, files and information relating to said patient which are in the practitioner's custody, possession or control, or copies of such documents hereinbefore described.

(d) A practitioner shall exercise reasonable care and diligence in the treatment of patients based upon generally accepted scientific principles, methods, treatments, and current professional theory and practice.

(e) A practitioner shall not represent, advertise, state or indicate the possession of any degree recognized as the basis for licensure to practice medicine or osteopathic medicine unless the practitioner is actually licensed on the basis of such degree in the state(s) in which he/she practices.

(f) A practitioner shall make reasonable efforts to obtain consultation whenever requested to do so by a patient or by those responsible for a patient's care. Further, the practitioner shall refer a patient to another practitioner in any case where the referring practitioner does not consider himself/herself qualified to treat the patient, and may refer the patient to another practitioner where the referring practitioner is unable to diagnose the illness or disease of the patient.

(g)(1) A practitioner who has personal knowledge based upon a reasonable belief that another practitioner holding the same licenses has engaged in illegal, unlawful, incompetent or fraudulent conduct in the practice of medicine or osteopathic medicine shall promptly report such conduct to a peer review or similar body, as defined in IC 34-4.12.6-1(c), having jurisdiction over the offending practitioner and the matter. This provision does not prohibit a practitioner from promptly reporting said conduct directly to the medical licensing board. Further, a practitioner who has personal knowledge of any person engaged in, or attempting to engage in, the unauthorized practice of medicine or osteopathic medicine shall promptly report such conduct to the medical licensing board.

(2) A practitioner who voluntarily submit himself/herself to, or is otherwise undergoing a course of treatment for, addiction, severe dependency upon alcohol or other drugs or controlled substances, or for psychiatric impairment, where such treatment is sponsored or supervised by an impaired physicians committee of a state, regional or local organization of professional health care providers, or where such treatment is sponsored or supervised by an impaired physician committee of a hospital, shall be exempt from reporting to a peer review committee as set forth in subsection (g)(1) or to the medical licensing board for so long as:

(A) the practitioner is complying with the course of treatment;

(B) the practitioner is making satisfactory progress.

If the practitioner fails to comply with or is not benefitted by, the course of treatment, the practitioner-chief administrative officer, his designee, or any member of, the impaired physicians committee shall promptly report such facts and circumstances to the medical licensing board. This subsection shall not, in any manner whatsoever, directly or indirectly, be deemed or construed to prohibit, restrict, limit or otherwise preclude the medical licensing board from taking such action as it deems appropriate or as may otherwise be provided by law.

(h)(1) Fees charged by a practitioner for his/her professional services shall be reasonable and shall reasonable [sic.] compensate the practitioner only for services actually rendered.

(2) A practitioner shall not enter into agreement for, charge, or collect an illegal or clearly excessive fee.

(3) Factors to be considered in determining the reasonableness of a fee include, but are not limited to, the following:

(A) the difficulty and/or uniqueness of the services performed and the time, skill and experience required;

(B) the fee customarily charged in the locality for similar practitioner services;

(C) the amount of the charges involved;

(D) the quality of performance;

(E) the nature and length of the professional relationship with the patient; and

(F) the experience, reputation and ability of the practitioner in performing the kind of services involved.

(i) A practitioner shall not divide a fee for professional services with another practitioner who is not a partner, employee, or shareholder in a professional corporation, unless:

(1) the patient consent to the employment of the other practitioner after a full disclosure that a division of fees will be made; and

(2) the division of fees is made in proportion to actual services performed and responsibility assumed by each practitioner.

(j) A practitioner shall not pay, demand, or receive compensation, for referral of a patient, except for a patient referral program operated by a medical society or association which is approved by the medical licensing board.

(k) A practitioner shall be responsible for the conduct of each and every person employed by the practitioner (whether such employee is a physician, nurse, physician's assistant, or other specific professional health care provider employed by the practitioner) for every action or failure to act by said employee or employees in the course of said employee(s) employment relationship with said practitioner; provided, however, that a practitioner shall not be responsible for the actions of persons he/she may employ whose employment by the practtitioner's [sic.] practice of medicine or of osteopathic medicine.

(l)(1) A practitioner shall not, on behalf of himself/herself, a partner, associate, shareholder in a professional corporation, or any other practitioner or specific health care provider affiliated with the practitioner, use, or participate in the use of, any form of public communication containing a false, fraudulent, misleading, deceptive or unfair statement or claim.

IOWA

PRINCIPLES OF PROFESSIONAL ETHICS

470—135.401(147,148,258A) Principles of medical ethics. The following principles of medical ethics prepared and approved by the judicial council of the American Medical Association, which are set out in a 1977 publication entitled "Opinions and Reports of the Judicial Council", published by the American Medical Association, 535 North Dearborn Street, Chicago, Illinois, 61610, are hereby adopted by the board relative to the practice of medicine and surgery in this state:

135.401(1) These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

135.401(2) The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

135.401(3) Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

135.401(4) A physician should practice a method of healing founded on a scientific basis; and he/she should not voluntarily associate professionally with anyone who violates this principle.

135.401(5) The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

135.401(6) A physician may choose whom he/she will serve. In an emergency, however, he/she should render service to the best of his/her ability. Having undertaken the case of a patient, he/she may not neglect him; and unless he/she has been discharged he/she may discontinue his/her services only after giving adequate notice. He/she should not solicit patients.

135.401(7) A physician should not dispose of his/her services under terms or conditions which tend to interfere with or impair the free and complete exercise of his/her medical judgment and skill or tend to cause a deterioration of the quality of medical care.

135.401(8) In the practice of medicine a physician should limit the source of his/her professional income to medical services actually rendered by him/her, or under his/her supervision to his/her patients. His/her fee should be commensurate with the services rendered and the patient's ability to pay. He/she should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

135.401(9) A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

135.401(10) A physician may not reveal the confidences entrusted to him/her in the course of medical attendance, or the deficiencies he/she may observe in the character of patients, unless he/she is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

135.401(11) The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his/her interest and participation in activities which have the purpose of improving both the health and well-being of the individual and the community.

470—135.402(147,148,258A) Code of ethics of osteopathic profession. The following code of ethics published and approved by the American osteopathic association and published in a book entitled "1977 American Osteopathic Association Year Book and Director of

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Osteopathic Physicians", is hereby adopted by the board relative to the practice of osteopathic medicine and surgery and osteopathy in this state:

135.402(1) The physician shall keep in confidence whatever he/she may learn about a patient in the discharge of professional duties. Information shall be divulged by the physician when required by law or when authorized by the patient.

135.402(2) The physician shall give a candid account of the patient's condition to the patient or to those responsible for the patient's care.

135.402(3) A physician-patient relationship must be founded on mutual trust, co-operation, and respect. The patient, therefore, must have complete freedom to choose his physician. The physician must have complete freedom to choose patients whom he/she will serve. In emergencies, a physician should make his/her services available.

135.402(4) The physician shall give due notice to the patient or to those responsible for the patient's care when he withdraws from a case so that another physician may be summoned.

135.402(5) A physician is never justified in abandoning a patient.

135.402(6) A physician shall practice in accordance with the body of systematized knowledge related to the healing arts and shall avoid professional association with individuals or organizations which do not practice or conduct organization affairs in accordance with such knowledge.

135.402(7) A physician shall not be identified in any manner with testimonials for proprietary products or devices advertised or sold directly to the public.

135.402(8) A physician shall not hold forth or indicate possession of any degree recognized as the basis for licensure to practice the healing arts unless he/she is actually licensed on the basis of that degree in the state in which he practices.

135.402(9) A physician shall obtain consultation whenever requested to do so by the patient. A physician should not hesitate to seek consultation whenever he himself/she herself believes it advisable.

135.402(10) Illegal, unethical or incompetent conduct of physicians shall be revealed to the proper tribunals.

135.402(11) A physician shall not assume treatment of a patient under the care of another physician except in emergencies and only during the time that the attending physician is not available unless requested by the patient.

135.402(12) Any fee charged by a physician shall be reasonable.

135.402(13) A physician shall not pay or receive compensation for referral of patients.

135.402(14) The physician shall co-operate fully in complying with all laws and regulations pertaining to practice of the healing arts and protection of the public health.

Rules 135.401 and 135.402 are intended to implement sections 147.55 and 147.76 of the Code.

135.403 to 135.500 Reserved.

CONTINUING EDUCATION

470—135.501(258A) **Definitions.** For the purpose of these rules, the following definitions shall apply.

135.501(1) *"Board"* means the board of medical examiners, created pursuant to chapter 147 of the Code.

135.501(2) *"Licensee"* means any person licensed to practice medicine and surgery, osteopathy and osteopathic medicine and surgery in the state of Iowa.

135.501(3) *"Continuing education"* means that education which is obtained by a person licensed to practice medicine and surgery, osteopathy and osteopathic medicine and surgery in order to maintain, improve, or expand skills and knowledge obtained prior to initial licensure or to develop new and relevent skills and knowledge.

135.501(4) *"Hour of continuing education"* means a clock-hour spent after December 31, 1978, by a licensee in actual attendance at or completion of an approved continuing education activity.

KENTUCKY BOARD OF MEDICAL LICENSURE

THE MALL OFFICE CENTER
400 SHERBURN LANE, SUITE 222
LOUISVILLE, KENTUCKY 40207

May 28, 1986

Minnesota Board of Medical Examiners
Suite 106
2700 University Ave. W.
St. Paul, MN 55114-1080

Dear Mr. Auld:

Per your letter of May 21, 1986, the Kentucky Board of Medical Licensure does not have any statute, administrative rules, or policy statment on fee splitting.

I am sorry we cannot assist you in gathering this information.

Sincerely,

C. William Schmidt

C. William Schmidt
Executive Director

CWS/bek

KANSAS

(4) The use of any letters, words, or terms, as an affix, on stationery, in advertisements, or otherwise indicating that such person is entitled to practice a branch of the healing arts for which such person is not licensed.

(5) Performing, procuring or aiding and abetting in the performance or procurement of a criminal abortion.

(6) Willful betrayal of confidential information.

(7) Advertising professional superiority or the performance of professional services in a superior manner.

(8) Advertising to guarantee any professional service or to perform any operation painlessly.

(9) Participating in any action as a staff member of a medical care facility which is designed to exclude or which results in the exclusion of any person licensed to practice medicine and surgery from the medical staff of a nonprofit medical care facility licensed in this state because of the branch of the healing arts practiced by such person or without just cause.

(10) Failure to effectuate the declaration of a qualified patient as provided in subsection (a) of K.S.A. 65-28,107 and amendments thereto.

(11) Prescribing, ordering, dispensing, administering, selling, supplying or giving any amphetamines or sympathomimetic amines, except as authorized by K.S.A. 65-2837a *and amendments thereto.*

(12) Conduct likely to deceive, defraud or harm the public.

(13) Making a false or misleading statement regarding the licensee's skill or the efficacy or value of the drug, treatment or remedy prescribed by the licensee or at the licensee's direction in the treatment of any disease or other condition of the body or mind.

(14) Aiding or abetting the practice of the healing arts by an unlicensed, incompetent or impaired person.

(15) Allowing another person or organization to use the licensee's license to practice medicine.

(16) Commission of any act of sexual abuse, misconduct or exploitation related to the licensee's practice of medicine.

(17) The use of any false, fraudulent or deceptive statement in any document connected with the practice of the healing arts.

(18) Obtaining any fee by fraud, deceit or misrepresentation.

(19) Directly or indirectly giving or receiving any fee, commission, rebate or other compensation for professional services not actually and personally rendered, other than through the legal functioning of lawful professional partnerships, corporations or associations.

(20) Failure to transfer medical records to another physician when requested to do so by the subject patient or by such patient's legally designated representative.

(21) Performing unnecessary tests, examinations or services which have no legitimate medical purpose.

(22) Charging an excessive fee for services rendered.

(23) Prescribing, dispensing, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper or inappropriate manner or quantity or not in the course of the licensee's professional practice.

(24) Repeated failure to practice healing arts with that level of care, skill and treatment which is recognized by

State of Maryland

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BOARD OF MEDICAL EXAMINERS
201 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201 • Area Code 301-225-5900

TTY FOR DEAF: Balto. 383-7555
D.C. Metro 565-0451

May 29, 1986

Richard L. Auld
Assistant Executive Director
Minnesota Board of Medical Examiners
Suite 106
2700 University Ave., W.
St. Paul, MN 55114-1080

Dear Mr. Auld:

Your correspondence has been referred to the Medical and Chirurgical Faculty of Maryland for response.

Sincerely,

Patricia Carrington
Executive Director

PC/dw

cc: Elza Davis

State of Maryland

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BOARD OF MEDICAL EXAMINERS
201 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201 • Area Code 301-225-5900

TTY FOR DEAF: Balto. 383-7555
D.C. Metro 565-0451

May 29, 1986

Elza Davis
Acting Executive Director
Medical & Chirurgical Faculty of Md.
1211 Cathedral Street
Baltimore, Maryland 21201

Dear Elza,

Attached is correspondence from the Minnesota Board. Since the Board of Medical Examiners is not involved in fee splitting, would you share with Mr. Auld, the Faculty's opinion on this issue?

Sincerely,

Patricia Carrington
Executive Director

PC/dw

Enclosure

cc: Richard L. Auld

MEDICAL and CHIRURGICAL FACULTY
of the STATE OF MARYLAND

1211 Cathedral Street Baltimore, Maryland 21201
(301) 539-0872 • Toll Free 1-800-492-1056

June 11, 1986

Richard L. Auld
Assistant Executive Director
Minnesota Board of Medical Examiners
Suite 106
2700 University Avenue West
St. Paul, Minnesota 55114-1080

Dear Mr. Auld:

Your letter of May 21, 1986 to the Maryland State Board of Medical Examiners was forwarded to me for response. I am enclosing the Faculty's ethical opinions concerning fee splitting and the newly enacted Maryland law on this subject. You might wish also to check with the Maryland Commission on Medical Discipline, the disciplinary arm of the Board, as to its policy concerning this law.

Please call on me if I can be of further assistance.

Very truly yours,

Judith A. Wood
Legal Counsel

JAW:jt
Enclosure

cc: Patricia Carrington, Board of Medical Examiners

406. FINANCIAL INCENTIVES

The primary obligation of every physician is to deliver high quality care to the patient. Physicians should always act with complete integrity and competence, devoted always to the interests of the individual patient when delivering this care. Reductions in medical care (for example fewer tests or shorter stays) are not necessarily at odds with the administration of proper care. However, participation by physicians in incentive programs, especially those offering financial rewards, should not interfere with their independent, professional judgment.

Accordingly, physicians should avoid incentive programs in which financial considerations are given undue weight in determining the services to be performed to the extent that the quality of medical care is adversely affected. (PEC 9/4/84)

Opinion of Maryland's Medical Society:

500. PROFESSIONAL INCOME AND FEES

501. DIVISION OF FEES

The following arrangements tend to exploit the patient for financial gain and, therefore, constitute an unethical division of fees:

.01 A voluntary prospective agreement between physicians for division of medical fees which is not based upon the physicians' services, responsibility, experience, or other contributions.

(a) Group Practice Referrals between members of a group practice (partnership, professional corporation and other similar entities) are not inherently unethical, and in fact, are to be encouraged when use of the group's resources results in convenience and savings to the patient. However, the physician must always act in the best interests of the patient. Accordingly, it is unethical for a physician to make medically unnecessary referrals to other members of the group practice or to make excessive use of the group's medical services.

(b) Husband/Wife Physician Teams Referrals between spouses are not inherently unethical, however, the best interests of the patient must always be foremost. The spousal relationship must always be disclosed to the patient when making such referrals. It is unethical to make medically unnecessary or excessive referrals between spouses.

(c) Clinic or Laboratory Joint Stock Company Joint stock companies of physicians organized for the purpose of operating a clinic or laboratory with the stock owned in part or whole by physicians connected only as stockholders may ethically be formed provided

that an owner physician who refers his patient to that clinic or laboratory discloses that he has an ownership interest. However, it is unethical for an owner physician to make excessive use of the facility.

.02 A voluntary prospective agreement between a physician and any other person (including, but not limited to, physicians and health care professionals) for the division of medical fees based upon the referral of patients.

(a) Partnership Between Physicians and Non-Physicians Partnership agreements may be made between physicians and non-physicians provided that policy for patient care is determined solely by physicians.

(b) Percentage Leases Physicians may ethically enter into percentage leases. (One type of percentage lease provides that the physician's rent for office space, personnel and other similar services from a lessor be based upon a percentage of his medical fees.) It is unethical for the physician lessee to accept medically unnecessary or excessive referrals from the lessor.

.03 Physicians who accept compensation from any source (e.g. pharmaceutical company, pharmacist, optical company or manufacturer of medical appliances or devices) for referral of patients to said source for the purchase of said medical goods or services.

(a) Drug Companies A physician may not accept compensation of any kind from a drug company for prescribing its products or from a pharmacy for referral of patients.

(b) Clinics or Laboratories A physician may not accept compensation from clinics or laboratories based upon the amount of work referred by the physician to the clinic or laboratory. (Further statements concerning volume discounts are listed under laboratories in Section 108. of the Faculty's Ethical Statements.) (PEC 6/5/84)

502. ADVANCE PAYMENT FOR MEDICAL SERVICES

.01 Under ordinary circumstances, physicians would not require payment in advance of providing medical services. It is considered ethical for physicians to adopt a policy that payment for office services be made at the time of service being rendered. It is good practice to fully advise patients of such policies in advance of treatment. Proper communication cannot be overstressed.

.02 However, it is not unethical for a physician to require payment in advance for treatments such as plastic surgery, obstetrical care (sometimes paid for on a monthly basis during pregnancy), therapeutic abortion, psychiatric or

HOUSE OF DELEGATES

61r2098 No. 1637 J2

By: Delegates Young, Arnick, Hollinger, Goldwater, and Menes
Introduced and read first time: February 5, 1986
Assigned to: Environmental Matters

A BILL ENTITLED

AN ACT concerning

Physicians - Disciplinary Actions

FOR the purpose of prohibiting physicians from accepting or agreeing to accept certain payments for bringing or referring patients; and generally relating to grounds for disciplinary actions against physicians.

BY repealing and reenacting, with amendments,

Article - Health Occupations
Section 14-504(16)
Annotated Code of Maryland
(1981 Volume and 1985 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article - Health Occupations

14-504.

Subject to the hearing provisions of § 14-505 of this subtitle, the Commission, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

(16) Pays or agrees to pay any sum to any person for bringing or referring a patient OR ACCEPTS OR AGREES TO ACCEPT ANY SUM FROM ANY PERSON FOR BRINGING OR REFERRING A PATIENT;

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 1986.

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.
[Brackets] indicate matter deleted from existing law.

HOUSE OF DELEGATES

61r2098 No. 1637 J2

By: Delegates Young, Arnick, Hollinger, Goldwater, and Menes
Introduced and read first time: February 5, 1986
Assigned to: Environmental Matters

Committee Report: Favorable
House action: Adopted
Read second time: March 19, 1986

CHAPTER _____

AN ACT concerning

Physicians - Disciplinary Actions

FOR the purpose of prohibiting physicians from accepting or agreeing to accept certain payments for bringing or referring patients; and generally relating to grounds for disciplinary actions against physicians.

BY repealing and reenacting, with amendments,

Article - Health Occupations
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Article - Health Occupations

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(16) Pays or agrees to pay any sum to any person for bringing or referring a patient OR ACCEPTS OR AGREES TO ACCEPT ANY SUM FROM ANY PERSON FOR BRINGING OR REFERRING A PATIENT;

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.
[Brackets] indicate matter deleted from existing law.
Underlining indicates amendments to bill.
~~Strike-out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

JAMES J. BLANCHARD, Governor

DEPARTMENT OF LICENSING AND REGULATION

RAYMOND W. HOOD, SR., Director
P.O. Box 30018
Lansing, Michigan 48909
Telephone: (517) 373-1870

May 29, 1986

Mr. Richard L. Auld,
Assistant Executive Director
Minnesota Board of Medical Examiners
Executive Office
Suite 106
2700 University Avenue West
St. Paul, Minnesota 55114-1080

Dear Mr. Auld:

In response to your request of May 21, 1986, enclosed is a copy of Section 333.16221 of the Michigan Public Health Code, which sets forth the grounds for disciplinary action by the Michigan Board of Medicine.

If you should desire further information, please contact me at 517/373-6873.

Sincerely,

Marcia Malouin,
Licensing Supervisor
Licensing Division
Bureau of Health Services

Enclosure

mm/dls

otherwise qualified by education, training, or experience the performance of selected acts, tasks, or functions where the acts, tasks, or functions fall within the scope of practice of the licensee's profession and will be performed under the licensee's supervision. An act, task, or function shall not be delegated under this section which, under standards of acceptable and prevailing practice, requires the level of education, skill, and judgment required of a licensee under this article.

(2) A board may promulgate rules to further prohibit or otherwise restrict delegation of specific acts, tasks, or functions to a licensed or unlicensed individual where the board determines that the delegation constitutes or may constitute a danger to the health, safety, or welfare of the patient or public.

(3) To promote safe and competent practice, a board may promulgate rules to specify conditions under which, and categories and types of licensed and unlicensed individuals for whom, closer supervision may be required.

(4) An individual who performs acts, tasks, or functions delegated pursuant to this section does not violate the part which regulates the scope of practice of that health profession.

History: 1978, Act 368, Eff. Sept. 30, 1978.

333.16221 Investigation of licensee; hearings; oaths; and testimony; report; grounds for proceeding under §333.16226.

Sec. 16221. The department may investigate the activities of a licensee related to the licensee's practice of the health profession. The department may hold hearings, administer oaths, and order relevant testimony to be taken and shall report its findings to the appropriate board or appropriate task force. The board shall proceed under section 16226 when the board finds that any of the following grounds exist:

(a) A violation of general duty, consisting of negligence or failure to exercise due care, including negligent delegation to or supervision of employees or other individuals, whether or not injury results, or any conduct, practice, or condition which impairs, or may impair, the ability to safely and skillfully practice the health profession.

(b) Personal disqualifications, consisting of any of the following:

(*i*) Incompetence.

(*ii*) Substance abuse as defined in section 6107.

(*iii*) Mental or physical inability reasonably related to and adversely affecting the licensee's ability to practice in a safe and competent manner.

(*iv*) Declaration of mental incompetence by a court of competent jurisdiction.

(c) Conviction of a misdemeanor or felony reasonably related to and adversely affecting the licensee's ability to practice in a safe and competent manner. A certified copy of the court record is conclusive evidence as to the conviction.

(d) Prohibited acts, consisting of any of the following:

(*i*) Fraud or deceit in obtaining a license.

(*ii*) Permitting the license to be used by an unauthorized person.

(*iv*) Obtaining, possessing, or attempting to obtain or possess a controlled substance as defined in section 7104 without lawful authority; or selling, prescribing, giving away, or administering drugs for other than lawful diagnostic or therapeutic purposes.

(d) Unethical business practices, consisting of any of the following:

(*i*) False or misleading advertising.

(*ii*) Dividing fees for referral of patients or accepting kickbacks on medical or surgical services, appliances, or medications purchased by or in behalf of patients.

(*iii*) Fraud or deceit in obtaining or attempting to obtain third party reimbursement.

(e) Unprofessional conduct, consisting of any of the following:

(*i*) Misrepresentation to a consumer or patient or in obtaining or attempting to obtain third party reimbursement in the course of professional practice.

(*ii*) Betrayal of a professional confidence.

(*iii*) Promotion for personal gain of an unnecessary drug, device, treatment, procedure, or service, or directing or requiring an individual to purchase or secure a drug, device, treatment, procedure, or service from another person, place, facility, or business in which the licensee has a financial interest.

(f) Failure to report a change of name or address within 30 days after it occurs.

(g) A violation, or aiding or abetting in a violation, of this article or of rules promulgated under this article.

(h) Failure to comply with a subpoena issued pursuant to this part.

(i) Failure to pay an installment of an assessment levied pursuant to section 2504 of Act No. 218 of the Public Acts of 1956, as amended, being section 500.2504 of the Michigan Compiled Laws, within 60 days after notice by the appropriate board.

History: 1978, Act 368, Eff. Sept. 30, 1978.

333.16224 Failure or refusal to submit to examination as ground for suspension of license; additional grounds for disciplinary actions.

Sec. 16224. (1) Failure or refusal to submit to an examination which a board is authorized to require under this part after reasonable notice and opportunity, constitutes a ground for suspension of a license until the examination is taken.

(2) Additional grounds for disciplinary action may be found in a part dealing with a specific health profession.

History: 1978, Act 368, Eff. Sept. 30, 1978.

333.16226 Sanctions.

Sec. 16226. After finding the existence of 1 or more of the grounds for board action described in section 16221 or in another part of this article, and after an opportunity for a hearing, a board shall impose 1 or more of the following sanctions for each violation:

Violations of Section 16221	Sanctions
Subdivision (a), (b)(*ii*), or (b)(*iv*)	Probation, limitation, denial, suspension, or revocation.

State of Missouri

John Ashcroft, Governor

Department of Economic Development
Division of Professional Registration

Carl M. Koupal, Jr., Director
Tony Feather, Director

State Board of Registration for the Healing Arts
P.O. Box 4
Jefferson City, Missouri 65102
Telephone 314/751-2334

Gary R. Clark, Executive Secretary

June 2, 1986

Mr. Paul L. Auld
Assistant Executive Director
Minnesota Board of Medical Examiners
2700 University Avenue West, Suite 106
St. Paul, Minnesota 55114-1080

Dear Mr. Auld,

Fee spliting is considered illegal under the general guise of the unethical or unprofessional conduct language of the Medical Practice Act. The Missouri Board has no additional specification of this as an actionable offense.

Sincerely,

Gary R. Clark

Gary R. Clark
Executive Secretary

GRC/kr

fees as outlined in section 71-110. A license to practice a profession may also be refused renewal or revoked when the licensee is guilty of practicing such profession while his license to do so is suspended or is guilty of practicing such profession in contravention of any limitation placed upon his license.

Source: Laws 1927,c.167,§46,p.466;C.S.1929,§71-601;Laws 1943,c.150,§10,p.541;R.S.1943,§71-147; Laws 1976,LB 877,§1;Laws 1979,LB 95,§1. Effective date August 24, 1979.

71-147.01. Peer review committee; health practitioners; slander, libel, defamation of character, privileged communication, or other actions; exempt; when. No member of a peer review committee of a state or local association or society composed of health practitioners licensed pursuant to the provisions of Chapter 71, article 1, shall be liable in damages to any person for slander, libel, defamation of character, breach of any privileged communication, or otherwise for any action taken or recommendation made within the scope of the functions of such committee, if such committee member acts without malice and in the reasonable belief that such action or recommendation is warranted by the facts known to him after a reasonable effort is made to obtain the facts on which such action is taken or recommendation is made.

Source: Laws 1976,LB 586,§1.

71-148. License; revocation or suspension; unprofessional conduct, defined. For the purpose of section 71-147, unprofessional conduct shall include any of the following acts: (1) Solicitation of professional patronage by agents or persons, popularly known as cappers or steerers, or profiting by the acts of those representing themselves to be agents of the licensee; (2) receipt of fees on the assurance that a manifestly incurable disease can be permanently cured; (3) division of fees, or agreeing to split or divide the fees,

NEBRASKA

received for professional services with any person for bringing or referring a patient; (4) assisting in the care or treatment of a patient without the consent of such patient or his or her legal representative; (5) the use of any letters, words, term or terms, either as a prefix, affix or suffix, on stationery, in advertisements, or otherwise, indicating that such person is entitled to practice a system or mode of healing for which he or she is not licensed; (6) performing, procuring or aiding and abetting in the performance or procurement of a criminal abortion; (7) willful betrayal of a professional secret; (8) making use of any advertising statements of a character tending to deceive or mislead the public; (9) advertising professional superiority or the performance of professional services in a superior manner; (10) advertising to guarantee any professional service, or to perform any operations, painlessly; (11) the performance by a physician of an abortion, as defined in subdivision (1) of section 28-326, under circumstances when he or she will not be available for a period of at least forty-eight hours for post-operative care unless such post-operative care is delegated to and accepted by another physician; and (12) performing an abortion upon a minor without having satisfied the notice requirements of section 28-347.

Source: Laws 1927,c.167,§47,p.466;C.S.1929,§71-602;Laws 1935,c.141,§1,p.518;C.S.Supp.,1941,§71-602;Laws 1943,c.146,§11,p.542;R.S.1943,§71-148; Laws 1979,LB 95,§2;Laws 1981,LB 466,§1. Effective date May 29, 1981.

71-149. License; disciplinary action; who may bring; failure to pay renewal fee; effect; other causes; petition; filing. The Director of Health shall have jurisdiction of proceedings to deny the application of an applicant or refuse renewal of, limit, revoke, suspend or, in accordance with section 71-155, take other disciplinary measures against the license of any licensee practicing under this act. When any licensee shall fail to

President
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KATHLEEN EBNER
EVA G. SIMMONS
LEO A. WILNER

Nevada State Board of Medical Examiners

KATHLEEN LEWIS, Executive Director

June 4, 1986

MEMO:

Per telephone conversation today, enclosed is copy of our statutes that you requested.

(702) 329-2559 • Post Office Box 7238 • Reno, Nevada 89510

Nevada

to practice medicine by any other jurisdiction or the surrender of the license or discontinuing the practice of medicine while under investigation by any licensing authority, a medical facility, a branch of the armed services of the United States, an insurance company, an agency of the Federal Government or an employer.

3. Gross or repeated malpractice, which may be evidenced by claims of malpractice settled against a practitioner.

(Added to NRS by 1977, 824; A 1981, 590; 1983, 305; 1985, 2236)

630.304 Grounds for initiating disciplinary action. The following acts, among others, constitute grounds for initiating disciplinary action:

1. Obtaining, maintaining or renewing or attempting to obtain, maintain or renew a license to practice medicine by bribery, fraud or misrepresentation or by any false, misleading, inaccurate or incomplete statement.

2. Advertising the practice of medicine in a false, deceptive or misleading manner.

3. Practicing or attempting to practice medicine under another name.

4. Signing a blank prescription form.

5. Influencing a patient in order to engage in sexual activity with the patient or with others.

6. Attempting directly or indirectly, by way of intimidation, coercion or deception, to obtain or retain a patient or to discourage the use of a second opinion.

7. Terminating the medical care of a patient without adequate notice or without making other arrangements for the continued care of the patient.

(Added to NRS by 1983, 301; A 1985, 2236)

630.305 Grounds for initiating disciplinary action. The following acts, among others, constitute grounds for initiating disciplinary action:

1. Directly or indirectly receiving from any person, corporation or other business organization any fee, commission, rebate or other form of compensation which is intended or tends to influence the physician's objective evaluation or treatment of a patient.

2. Dividing a fee between licensees except where the patient is informed of the division of fees and the division of fees is made in proportion to the services personally performed and the responsibility assumed by each licensee.

3. Charging for visits to the physician's office which did not occur or for services which were not rendered or documented in the records of the patient.

4. Aiding, assisting, employing or advising, directly or indirectly, any unlicensed person to engage in the practice of medicine contrary to the provisions of this chapter or the regulations of the board.

State of New Hampshire

BOARD OF REGISTRATION IN MEDICINE

HEALTH & WELFARE BUILDING — HAZEN DRIVE
CONCORD, NEW HAMPSHIRE 03301

TEL. (603) 271-4502

BOARD MEMBERS
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WILLIAM T. WALLACE, Jr., M.D.
EXECUTIVE SECRETARY

June 23, 1986

Minnesota Board of Medical Examiners
Suite 106
2700 University Avenue West
St. Paul, MN 55114-1080

ATTN: Fee Splitting Study

Dear Mr. Auld:

This is in response to your letter of May 21, 1986 regarding fee splitting.

The State of New Hampshire does not have any laws, rules or regulations regarding fee splitting at the present time.

Sincerely,

Jean A. Barnes

Jean A. Barnes
Administrative Assistant

/jab

State of New Jersey
DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
BOARD OF MEDICAL EXAMINERS
28 WEST STATE STREET
TRENTON, N.J. 08608
(609) 292-4843

W. CARY EDWARDS
ATTORNEY GENERAL

JAMES J. BARRY, JR.
DIRECTOR

June 3, 1986

Richard L. Auld
Assistant Executive Director
Minnesota Board of Medical Examiners
2700 University Ave. West Suite 106
St. Paul, MN 55114-1080

Dear Mr. Auld:

I am in receipt of your recent correspondence regarding the Minnesota Board proposing an administrative rule on fee-splitting.

Enclosed please find a copy of N.J.A.C. 13:35-6.4. This regulation addresses kickbacks, rebates or payments received for services not rendered.

Should you have any questions after review of this regulation, please advise.

Very truly yours,

Charles A. Janousek
Executive Secretary

CAJ/bp
Enclosure

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13:35-6.3 Countersigning of orders and prescriptions of unlicensed physicians

(a) The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

"Intern" or "PGY 1" (a person studying in postgraduate year one) shall mean an unlicensed graduate of a medical school, who is engaged in a program which has been approved by the Board and which consists of supervised practice in the science and art of medicine among patients in a hospital with continued instruction by the staff of the facility. The internship period shall be limited to one year.

"Resident" or "PGY 2 or 3" shall mean a licensed or unlicensed graduate of an approved internship or PGY 1 who is engaged in an approved program for advanced training in a clinical division of medicine, surgery or other special field in preparation for the practice of a specialty, which training shall be continuously supervised by the staff of the facility. Such approved program must be properly accredited for residency training in the specialty program or programs offered.

"Unlicensed physician" shall mean any unlicensed graduate of a medical school such as, but not limited to, an intern or resident who is engaged in an approved program or a person possessing an exemption pursuant to N.J.S.A. 45:9-21(n).

(b) A doctor's order written for a patient's care by an unlicensed person engaged in an intern or residency training program in a hospital or institution approved by the Board, or the doctor's order written by a person exempted from the prohibitory provisions of the Medical Practice Act pursuant to N.J.S.A. 45:9-21(n) shall be countersigned within 24 hours by a physician possessing a current unrestricted license to practice medicine and surgery in this State.

(c) Prescriptions written by unlicensed physicians which are to be filled by a pharmacy located outside the hospital or institution where such unlicensed physician is engaged must be countersigned by a physician possessing a current, unrestricted license to practice medicine and surgery in this State.

13:35-6.4 Prohibition of kickbacks, rebates or receiving payment for services not rendered

(a) It shall be unprofessional or unethical conduct for any licensee or registrant of the State Board of Medical Examiners to:

1. Receive directly or indirectly from any person, firm or corporation any fee, commission, rebate, gift or other form of compensation for prescribing, ordering or promoting the sale of a device, appliance or other prescribed item or service when such device, appliance or prescribed item or service is provided by another;

2. Directly or indirectly charge or bill the recipient of a device, appliance or prescribed item, or directly or indirectly charge or bill any

NEW JERSEY

third party when such device, appliance or prescribed item is delivered by the licensee or registrant without disclosing to the recipient and third party, if any, the actual cost to the licensee or registrant for such device, appliance or prescribed item which the licensee or registrant paid or shall pay to the provider of such device, appliance or prescribed item;

3. Receive directly or indirectly from any person, firm or corporation any fee, gift, commission, rebate, free saleable products, anything of value or any form of compensation for prescribing or promoting the sale of any drug, commodity or product;

4. Sell "free samples" or "samples" or other similar items obtained from any person, firm or corporation by such licensee or registrant;

5. Render any bill or invoice or receive any monies from any person, firm, corporation or governmental entity for the performance of services which were not, in fact, performed; provided, however, that this shall not be construed to prohibit an agreed charge for appointment made or services ordered notwithstanding subsequent patient or consumer cancellation.

13:35-6.5 Preparation of patient records and release thereof

(a) A patient record shall be prepared by all licensees and registrants of this Board and shall be maintained for seven years from date of last entry.

(b) Copies of all pertinent objective data and papers pertaining to a given patient, as well as a copy of the licensee's record or a summary report of such record shall be furnished to the patient or a designated licensee or duly authorized representative within 30 days of a written request by the patient or duly authorized representative. A reasonable charge may be made for such service.

(c) With respect to the non-objective records of a licensee or registrant, a partial record may be supplied where, in the reasonable exercise of professional judgment, the licensee or registrant believes that furnishing to or review by the patient of such records would be deleterious to the patient's best interests.

13:35-6.6 Requirements for issuing prescriptions for all medications; special requirements for prescribing or dispensing controlled drugs

(a) Physicians who possess a plenary license to practice medicine and surgery and podiatrists who issue prescriptions for medication shall advise all patients by adequate notice, such as but not limited to a sign or pamphlet in the waiting room of the practitioner's office, that a request of the practitioner may be made by the patient to substitute a generic drug for any prescribed medication.

NEW YORK

b. Having been found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state where the conduct upon which the finding was based would, if committed in New York state, constitute professional misconduct under the laws of New York state;

c. Having been found by the commissioner of health to be in violation of article thirty-three of the public health law.

d. Having his license to practice medicine revoked, suspended or having other disciplinary action taken, or having his application for a license refused, revoked or suspended or having voluntarily or otherwise surrendered his license after a disciplinary action was instituted by a duly authorized professional disciplinary agency of another state, where the conduct resulting in the revocation, suspension or other disciplinary action involving the license or refusal, revocation or suspension of an application for a license or the surrender of the license would, if committed in New York state, constitute professional misconduct under the laws of New York state.

6. Refusing to provide professional service to a person because of such person's race, creed, color, or national origin,

7. Permitting, aiding or abetting an unlicensed person to perform activities requiring a license,

8. Practicing the profession while the license is suspended, or wilfully failing to register or notify the department of any change of name or mailing address, or if a professional service corporation wilfully failing to comply with sections fifteen hundred three and fifteen hundred fourteen of the business corporation law,

9. Committing unprofessional conduct, as defined by the board of regents in its rules or by the commissioner in regulations approved by the board of regents,

10. A willful violation by a licensed physician of subdivision eleven of section two hundred thirty of the public health law, or

11. A violation of section twenty-eight hundred three-d or twenty-eight hundred five-k of the public health law.

12. Failure to comply with an order issued pursuant to subdivision seven of section two hundred thirty of the public health law.

§ 6509 – a. Additional definition of professional misconduct; limited application

Notwithstanding any inconsistent provision of this article or of any other provision of law to the contrary, the license or registration of a person subject to the provisions of articles one hundred thirty-one, one hundred thirty-one-a, one hundred thirty-two, one hundred thirty-three, one hundred thirty-seven, one hundred thirty-nine, one hundred forty-one, one hundred forty-three, one hundred forty-four, one hundred fifty-six and one hundred fifty-nine of this chapter may be revoked, suspended or annulled or such person may be subject to any other penalty provided in section sixty-five hundred eleven of this article in accordance with the provisions and procedure of this article for the following:

That any person subject to the above enumerated articles, has directly or indirectly requested, received or participated in the division, transference, assignment, rebate, splitting or refunding of a fee for, or has directly requested, received or profited by means of a credit or other valuable consideration as a commission, discount or gratuity in connection with the furnishing of professional care, or service, including x-ray examination and treatment, or for or in connection with the sale, rental, supplying or furnishing of clinical laboratory services or supplies, inhalation therapy service or equipment, ambulance service, hospital or medical supplies, physiotherapy or other therapeutic service or equipment, artifical limbs, teeth or eyes, orthopedic or surgical appliances or supplies, optical appliances, supplies or equipment, devices for aid of hearing, drugs, medication or medical supplies or any other goods, services or supplies prescribed for medical diagnosis, care or treatment, under this chapter, except payment, not to exceed thirty-three and one-third per centum of any fee received for x-ray examination, diagnosis or treatment, to any hospital furnishing facilities for such examination, diagnosis or treatment. Nothing contained in this section shall prohibit such persons from practicing as partners, in groups or as a professional corporation nor from pooling fees and moneys received, either by the partnerships, professional corporations or groups by the individual members, thereof, for professional services furnished by any individual professional member, or employee of such partnership, corporation or group, nor shall the professionals constituting the partnerships,

NEW YORK

poration or groups be probitited from sharing, divid-ng or apportioning the fees and moneys received by them or by the partnership, corporation or group in accordance with a partnership or other agreement; provided that no such practice as partners, corporations or in groups or pooling of fees or moneys received or shared, division or apportionment of fees shall be permitted with respect to care and treatment under the workmen's compensation law except as expressly authorized by the workmen's compensation law. Nothing contained in this chapter shall prohibit a medical or dental expense indemnity corporation pursuant to its contract with the subscriber from prorationing a medical or dental expense indemnity allowance among two or more professionals in proportion to the services rendered by each such professional at the request of the subscriber, provided that prior to payment thereof such professionals shall submit both to the medical or dental expense indemnity corporation and to the subscriber statements itemizing the services rendered by each such professional and the charges therefor.

§ 6510. Proceedings in cases of professional misconduct

In cases of professional misconduct the proceedings shall be as follows:

1. Preliminary procedures.

   a.Complaint. A complaint of a licensee's professional misconduct may be made by any person to the education department.

   b. Investigation. The department shall investigate each complaint which alleges conduct constituting professional misconduct. The results of the investigation shall be referred to the professional conduct officer designated by the board of regents pursuant to section sixty-five hundred six of this article. If such officer decides that there is not substantial evidence of professional misconduct or that further proceedings are not warranted, no further action shall be taken. If such officer, after consultation with a professional member of the applicable state board for the profession, determines that there is substantial evidence of professional misconduct, and that further proceedings are warranted, such proceedings shall be conducted pursuant to this section. If the complaint involves a question of professional expertise, then such officer may seek, and if so shall obtain, the concurrence of at least two members of a panel of three members of the applicable board.

   c. Charges. In all disciplinary proceedings other than those terminated by an administrative warning pursuant to paragraph a of subdivision two of this section, the department shall prepare the charges. The charges shall state the alleged professional misconduct and shall state concisely the material facts but not the evidience (sic) by which the charges are to be proved.

   d. Service of charges and of notice of hearing. A copy of the charges and notice of any hearing pursuant to subdivision two or three of this section shall be served on the licensee personally by the department at least fifteen days before the hearing. If personal service cannot be made after due diligence and such fact is certified under oath, a copy of the charges and the notice of hearing shall be served by certified mail, return receipt requested to the licensee's last known address by the department at least twenty days before the hearing.

2. Expedited procedures.

   a. Violations. Violations involving professional misconduct of a minor or technical nature may be resolved by expedited procedures as provided in paragraph b or c of this subdivision. For purposes of this subdivision, violations of a minor or technical nature shall include, but shall not be limited to, isolated instances of violations concerning professional advertising or record keeping, and other isolated violations which do not directly affect or impair the public health, welfare or safety. The board of regents shall make recommendations to the legislature on or before June first, nineteen hundred eighty-one, for the further definition of violations of a minor or technical nature. The initial instance of any violation of a minor or technical nature may be resolved by the issuance of an administrative warning pursuant to paragraph b of this subdivision. Subsequent instances of similar violations of a minor or technical nature within a period of three years may be resolved by the procedure set forth in paragraph c of this subdivision.

   b. Administrative warning. If a professional conduct officer, after consultation with a pro-

North Dakota State
Board of Medical Examiners

ROLF P. SLETTEN
Executive Secretary and Treasurer

LYNETTE LEWIS
Administrative Assistant

June 3, 1986

Richard L. Auld
Assistant Exec. Director
Minnesota Board of Medical Examiners
2700 University Ave. W, Suite 106
St. Paul, MN 55114-1080

RE: Fee Splitting

Dear Mr. Auld:

Unfortunately, I must advise you that our Board has no rules or policy statements pertaining to fee splitting.

Sincerely,

Rolf Sletten

ROLF P. SLETTEN
Executive Secretary
and Treasurer

RPS/ll

CITY CENTER PLAZA • 418 E. BROADWAY AVE., SUITE C-10 • BISMARCK, NORTH DAKOTA 58501
PHONE (701) 223-9485

STATE OF OHIO
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43266-0315

May 30, 1986

Richard L. Auld
Assistant Executive Director
Minnesota Board of Medical Examiners
2700 University Ave., West, Ste. 106
St. Paul, Minnesota 55114-1080

Dear Mr. Auld:

In response to your May 21, 1986 inquiry, I have enclosed a copy of Section 4731.22, Ohio Revised Code.

In particular, I refer you to division (B)(4) of that section. I am unaware of any specific policies which the Board has developed concerning this subject.

I trust this information will be of assistance to you.

Very truly yours,

Ray Q. Bumgarner
Executive Director

RQB:es
Encl.

(B) All persons who hold a certificate to practice a limited branch of medicine or surgery issued by the state medical board, whether residents of this state or not, shall on or before the first day of June, 1983, and on or before the first day of June every second year thereafter, register with the state medical board on a form prescribed by the board and shall pay at such time a biennial registration fee of twenty-five dollars. At least one month in advance of the date of registration, a written notice that the biennial registration fee is due on or before the first day of June shall be sent to each holder of a certificate to practice a limited branch of medicine or surgery, at the person's last known address. All persons who hold a certificate to practice a limited branch of medicine or surgery issued by the state medical board shall provide the board written notice of any change of address. A certificate to practice a limited branch of medicine or surgery shall be automatically suspended if the fee is not paid by the first day of September of the year it is due, and continued practice after the suspension of the certificate to practice shall be considered as practicing without a license in violation of sections 4731.34 and 4731.41 of the Revised Code. An applicant for reinstatement of a certificate to practice suspended for failure to register shall submit his current and delinquent registration fees and a penalty in the sum of twenty-five dollars.

Sec. 4731.16 Examination.

The examination of all applicants for certification to practice a limited branch of medicine or surgery shall be conducted under rules prescribed by the state medical board and at such times and places as the board may determine. Such examination shall be given in anatomy, physiology, chemistry, bacteriology, pathology, hygiene, diagnosis, and in such other subjects appropriate to the limited branches of medicine or for which certification is requested as the board may require. Applicants for certificates to practice massage or Swedish movements shall not be examined in pathology and diagnosis.

Sec. 4731.17 Aid authorized in conducting examinations.

For the purpose of conducting examinations provided for in section 4731.15 and 4731.16 of the Revised Code the state medical board shall call to its aid any person of established reputation and known ability in the particular limited branch in which the examination is being held. Any person called by the board to its aid, as provided in this section, shall be reimbursed for his services not more than fifty dollars per day and his actual and necessary expenses to be fixed and allowed by the board.

If the applicant passes such examination and has paid the fee of one hundred dollars, the board shall issue its certificate to that effect. Such certificate shall authorize the holder thereof to practice such limited branch of medicine or surgery as may be specified therein, but shall not permit him to practice any other branch of medicine or surgery nor shall it permit him to treat infectious, contagious, or venereal diseases, or to prescribe or administer drugs, or to perform surgery.

Sec. 4731.18 Board may dispense with examination.

The state medical board may dispense with the examination of applicants for limited certificates to practice a limited branch of medicine or surgery upon the same reciprocal conditions with respect to such limited branches as are provided in section 4731.29 of the Revised Code with respect to physicians and surgeons generally. In such cases the state medical board shall recognize national examining boards of the appropriate limited branches of medicine.

Sec. 4731.19 Board shall determine standing of school giving instruction.

The state medical board shall determine the standing of the schools, colleges, institutions, or individuals giving instruction in limited branches of medicine or surgery. If there shall at any time be such schools,

OHIO

colleges, institutions, or individuals giving instruction in such limited branches, the applicant for such certificate shall, as a condition of admission to the examination, produce a diploma or certificate from such a school, college, institution, or individual in good standing as determined by the board, showing the completion of the required courses of instruction.

The entrance examiner of the board shall determine the sufficiency of the preliminary education of applicants for such limited certificate as is provided in section 4731.09 of the Revised Code. The board may adopt rules defining and establishing for any limited branch of medicine or surgery such preliminary educational requirements, less exacting than those prescribed by such section, as the nature of the case may require.

Sec. 4731.20 Powers and duties of board.

Sections 4731.07, 4731.08, and 4731.14 to 4731.26 of the Revised Code shall govern the state medical board, all of the officers mentioned therein, and the applicants for and recipients of limited certificates to practice a limited branch of medicine or surgery. In addition to the power of the board to revoke and suspend certificates provided for in section 4731.22 of the Revised Code it may also revoke or suspend the certificate of any one to whom a limited certificate has been issued upon proof of violation of the rules established by the board governing such limited practice.

Sec. 4731.21 Limitations prescribed.

Sections 4731.15 to 4731.20, inclusive, of the Revised Code do not amend sections 4731.34, 4731.36, and 4731.41 of the Revised Code or limit their application unless otherwise specifically provided.

Sec. 4731.22 Grounds for discipline.

(A) The state medical board, by a vote of not less

ception in applying for or securing any license or certificate issued by the board.

(B) The board, by a vote of not less than six members, shall, to the extent permitted by law, limit, revoke, or suspend a certificate, refuse to register or refuse to reinstate an applicant, or reprimand or place on probation the holder of a certificate for one or more of the following reasons:

(1) Permitting one's name or one's certificate of registration to be used by a person, group, or corporation when the individual concerned is not actually directing the treatment given;

(2) Failure to use reasonable care discrimination in the administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease;

(3) Selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes or conviction of violation of any federal or state law regulating the possession, distribution, or use of any drug;

(4) Wilfully betraying a professional confidence or engaging in the division of fees for referral of patients, or the receiving of a thing of value in return for a specific referral of a patient to utilize a particular service or business;

(5) Soliciting patients or publishing a false, fraudulent, deceptive, or misleading statement.

As used in this division, "false, fraudulent, deceptive, or misleading statement" means a statement that includes a misrepresentation of fact, is likely to mislead or deceive because of a failure to disclose material facts, is intended or is likely to create false or unjustified expectations of favorable results, or includes representations or implications that in reasonable probability will cause an ordinarily prudent person to misunderstand or be decieved.

compensation or other advantage for himself or for any other person, that an incurable disease or injury, or other incurable condition, can be permanently cured;

(8) The obtaining of, or attempting to obtain, money or anything of value by fraudulent misrepresentations in the course of practice;

(9) Conviction of a felony whether or not committed in the course of his practice;

(10) Conviction of a misdemeanor committed in the course of his practice;

(11) Violation of the conditions of limitation placed by the board upon a certificate to practice or violation of the conditions of limitation upon which a limited or temporary registration or certificate to practice is issued;

(12) Failure to pay license renewal fees specified in this chapter;

(13) Any division of fees or charges, or any agreement or arrangement to share fees or charges, made by any person licensed to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery with any other person so licensed, or with any other person;

(14) The violation of any provision of a code of ethics of a national professional organization as specified in this division. "National professional organization" means the American medical association, the American osteopathic association, the American podiatry association, and such other national professional organizations as are determined, by rule, by the state medical board. The state medical board shall obtain and keep on file current copies of the codes of ethics of the various national professional organizations. The practitioner whose certificate is being suspended or revoked shall not be found to have violated any provision of a code of ethics of an organization not appropriate to his profession;

(15) Inability to practice according to acceptable and prevailing standards of care by reason of illness, excessive use of alcohol, excessive use of controlled substances, drugs, or chemicals, or as a result of a

mental or physical condition. In enforcing this division, the board upon a showing of a possible violation, may compel any individual licensed or certified to practice by this chapter or who has applied for licensure or certification pursuant to this chapter to submit to a mental or physical examination, or both, as required by and at the expense of the board. Failure of any individual to submit to a mental or physical examination when directed constitutes an admission of the allegations against him unless the failure is due to circumstances beyond his control, and a default and final order may be entered without the taking of testimony or presentation of evidence. If the board finds a physician unable to practice because of the reasons set forth in this division, the board shall require such physician to submit to care, counseling, or treatment by physicians approved or designated by the board, as a condition for initial, continued, reinstated, or renewed licensure to practice. An individual licensed by this chapter affected under this section shall be afforded an opportunity to demonstrate to the board that he can resume his practice in compliance with acceptable and prevailing standards under the provisions of his certificate. For the purpose of this section, any individual licensed or certified to practice by this chapter accepts the privilege of practicing in this state, and by so doing or by the making and filing of a registration or application to practice in this state, shall be deemed to have given his consent to submit to a mental or physical examination when directed to do so in writing by the board, and to have waived all objections to the admissibility of testimony or examination reports that constitute a privileged communication;

(16) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provisions of this chapter or any rule promulgated by the board;

(17) The violation of any abortion rule adopted by the public health council pursuant to section 3701.341 of the Revised Code;

(18) The revocation or suspension by another state of a license or certificate to practice issued by the

OHIO

proper licensing authority of that state for an action that would also have been a violation of this chapter except for nonpayment of fees.

(C) The clerk of each common pleas, municipal, or county court, or any other court of record in this state shall, on forms prescribed and furnished by the medical board, promptly notify the medical board of each conviction in such court of any person holding a valid certificate issued pursuant to Chapter 4731. of the Revised Code, who is convicted of a violation of Chapter 2907., 2925., or 3719. of the Revised Code in connection with his practice.

(D) (1) The board shall investigate evidence which appears to show that any person has violated any provision of this chapter, Chapter 4730. of the Revised Code, or rule of the board. For the purpose of investigation on matters concerning a possible violation of division (B) (3), (9), (10), (11), or (12) of section 4731.22 of the Revised Code, the board may administer oaths, order taking of depositions, issue subpoenas, compel the attendance of witnesses and the production of books, accounts, papers, records, documents, and testimony. The hearings and investigations of the board shall be considered civil actions for purposes of section 2305.251 of the Revised Code. In case of disobedience of any person with respect to an order or subpoena issued by the board, or on the refusal of a witness to testify to any matter regarding which he may be lawfully interrogated, a judge of the court of common pleas of the county in which the person resides, on application of the board, may compel obedience by attachment proceedings as for contempt, as in the case of disobedience with respect to the requirements of a subpoena issued from such court or a refusal to testify in such court. Each officer who serves such subpoena shall receive the same fees as a sheriff, and each witness who appears, in obedience to a subpoena, before the board, shall receive the fees and mileage provided for witnesses in civil cases in

person who reports such information or who testifies before the board in any adjudication hearing conducted under Chapter 119. of the Revised Code shall not be liable for civil damages as a result thereof.

Each complaint or allegation of a violation received by the board shall be assigned a case number and shall be recorded by the board. Investigations of alleged violations of this chapter, Chapter 4730. of the Revised Code, or any rule of the board shall be supervised by a board member selected on a rotating basis by the board. No member of the board who supervises the investigation of a case shall participate in further adjudication of the case.

The board shall conduct all investigations and proceedings in such a manner as to protect patient confidentially. The board shall obtain the consent of the patient in the form of a written release signed by the patient or by an authorized representative of the patient before seeking access to medical record information concerning a patient for the purpose of any investigation or hearing, except that no such consent is required if there is reason to believe that there has been a violation of division (B) (3) of section 4731.22 of the Revised Code. The board shall not make public names or other identifying information about patients unless proper consent is given or a waiver of the patient privilege exists under division (B) of section 2317.02 of the Revised Code, except that no such consent or waiver is required if the board possesses reliable and substantial evidence that no bona fide physician-patient relationship exists.

(2) If any individual licensed or certified to practice or any association or society or individuals licensed or certified under this chapter believes that a violation of any provision of this chapter, or Chapter 4730. of the Revised Code has occurred, he shall report to the

MAY 23 1986

Minnesota Board of Medical Examiners

EXECUTIVE OFFICE
Suite 106
2700 University Avenue West
St. Paul, Minnesota 55114-1080
(612) 642-0538

May 21, 1986

Oregon Board of Medical Examiners
John J. Ulwelling, Executive Secretary
1002 Loyalty Bldg. 317 S.W. Alder st.
Portland, OR 97204

Dear Mr. Ulwelling:

The Minnesota Board of Medical Examiners is in the process of gathering information prior to promulgating administrative rules on fee splitting.

To assist us in this process we request that you send us copies of any statute, administrative rules, or policy statement your Board has on this topic.

Please send these to:

Minnesota Board of Medical Examiners
Suite 106
2700 University Ave. W.
St. Paul, MN 55114-1080
Attention: Fee Splitting Study

If you have any questions or if I can be of assistance to you in responding please contact me at the above address or at (612) 642-0598.

Thank you for your cooperation.

Sincerely,

Richard L. Auld
Assistant Executive Director

SPEED LETTER

In the interest of speed and economy, we are answering your inquiry on your letter. If you need more information, please notify us and return this communication.

OREGON STATE BOARD OF MEDICAL EXAMINERS
317 S.W. Alder St., Suite 1002
Portland, Oregon 97204-2584

Dear Mr. Auld

We have ~~not~~ Administrative rules on policies regarding fee splitting. John J. Ulwelling 5/27/86

AN EQUAL OPPORTUNITY EMPLOYER

State of Rhode Island and Providence Plantations

Department of Health
CANNON BUILDING
Davis Street
Providence, R.I. 02908

29 May 1986

Mr. Richard L. Auld
Assistant Executive Director
Minnesota Board of Medical Examiners
Suite 106
2700 University Avenue, West
St. Paul, Minnesota 55114-1080

Dear Mr. Auld:

This is to acknowledge receipt of your letter dated 21 May 1986.

Enclosed please find a copy of Rhode Island's General Laws, Chapter 37.1 entitled Board of Medical Review. Specifically, I refer you to section 5-37.1-5 entitled unprofessional conduct and the sections that follow concerning due process.

If you have any questions please do not hesitate to contact this office.

Sincerely,

Robert W. McClanaghan, Administrator
Division of Professional Regulation

RWM/bjs

Enclosure

RHODE ISLAND

members or other witnesses and parties to board proceedings for any statements made by them in any reports, communications or testimony concerning an investigation of the conduct or competence of a licensed physician or limited registrant.

History of Section.
P. L. 1976, ch. 244, § 1; P.L. 1984, ch. 131, § 1.

5-37.1-5. Unprofessional conduct. — The term "unprofessional conduct" as used in this chapter shall mean the following items or any combination thereof which may be further defined by regulations established by the board of medical review:

(1) fraudulent or deceptive procuring or use of a license or limited registration;

(2) all advertising of medical business which is intended or has a tendency to deceive the public;

(3) conviction of a crime involving moral turpitude; conviction of a felony; conviction of a crime arising out of the practice of medicine;

(4) abandonment of a patient;

(5) addiction to narcotics, habitual drunkenness or rendering professional services to a patient while the physician or limited registrant is intoxicated or incapacitated by the use of drugs;

(6) promotion by a physician or limited registrant of the sale of drugs, devices, appliances, or goods or services provided for a patient in such manner as to exploit the patient for the financial gain of the physician or limited registrant;

(7) immoral conduct of a physician or limited registrant in the practice of medicine;

(8) willfully making and filing false reports or records in the practice of medicine;

(9) willful omission to file or record, or willfully impeding or obstructing a filing or recording, or inducing another person to omit to file or record medical reports as required by law;

(10) failure to furnish details of a patient's medical record to succeeding physicians or hospitals upon proper request. Proper request shall be defined to mean only on a patient's signed release and upon reimbursement of reasonable costs for reproducing said materials;

(11) solicitation of professional patronage by agents or persons or profiting from acts of those representing themselves to be agents of the licensed physician or limited registrants;

(12) division of fees or agreeing to split or divide the fees received for professional services for any person for bringing to or referring a patient;

(13) agreeing with clinical or bio-analytical laboratories to make payments to such laboratories for individual tests or test series for patients unless the physician or limited registrant discloses on the

RHODE ISLAND

bills to patients the name of such laboratory, the amount or amounts paid to such laboratory for individual tests or test series and the amount of his processing charge or procurement, if any, for each specimen taken;

(14) willful misrepresentation in treatments;

(15) practicing medicine with an unlicensed physician except in an accredited preceptorship or residency training program, or aiding or abetting such unlicensed persons in the practice of medicine;

(16) violation of the patient's bill of rights set forth in § 23-17-19.1;

(17) gross and willful and continued overcharging for professional services; including filing of false statements for collection of fees for which services are not rendered;

(18) offering, undertaking or agreeing to cure or treat disease by a secret method, procedure, treatment or medicine;

(19) failure to maintain standards established by peer review board including but not limited to standards related to proper utilization of services and use of non-accepted procedure;

(20) professional or mental incompetency;

(21) incompetent, negligent or willful misconduct in the practice of medicine which shall include any departure from or the failure to conform to the minimal standards of acceptable and prevailing medical practice in his area of expertise as shall be determined by the board. The board need not establish actual injury to the patient in order to adjudge a physician or limited registrant guilty of the above named conduct;

(22) failure to comply with the provisions of chapter 4.7 of title 23.

History of Section.
P.L. 1976, ch. 244, § 1; P.L. 1981, ch. 334, § 1; P.L. 1982, ch. 323, § 3; P.L. 1982, ch. 325, § 2; P.L. 1984, ch. 131, § 1.

NOTES TO DECISIONS

1. Purpose.

It is apparent from the face of this chapter that the board of medical review was established to insure that residents of Rhode Island receive health care from competent, principled physicians. Calenda v. Rhode Island Bd. of Medical Review, 565 F. Supp. 816 (D.R.I. 1983).

5-37.1-6. Complaints. — Any person, firm, corporation, or public officer may submit a written complaint to the board charging the holder of a license to practice medicine and surgery or limited registrant with unprofessional conduct, specifying the grounds therefor. If the board determines that such complaint merits consideration, or if the board, on its own initiative without a formal complaint has reasons to believe that any holder of a license or limited registration to practice medicine may be guilty of unprofessional conduct, the chairman shall designate three (3) members of the board, one (1) of whom shall be a public member, to serve as a committee to hear and report upon such charges. These preliminary investigations shall remain confidential unless the committee determines that the matter necessitates action by the entire board.

SOUTH Dakota

Department of Commerce & Consumer Affairs

STATE BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS
608 West Avenue North, Sioux Falls, South Dakota 57104
Phone 605/336-1965

May 30, 1986

Richard L. Auld
Assistant Executive Director
Minnesota Board of Medical Examiners
2700 University Ave., W., Suite 106
St. Paul, MN 55114-1080

Dear Mr. Auld:

Enclosed is a copy of the South Dakota Medical Practice Act and rules as requested in your letter of May 21. I hope that this information will be of assistance to you.

Very sincerely yours,

Patty Butler

(Mrs.) Patty Butler
Administrative Assistant

PB/js
enc.

36-4-28. Grounds for refusal of license. The board of examiners shall have power, in compliance with chapter 1-26, to refuse to grant a license under this chapter for unprofessional, immoral or dishonorable conduct on the part of the applicant.

36-4-29. Grounds for cancellation, revocation, suspension or limitation of license. The South Dakota state board of medical and osteopathic examiners may cancel, revoke, suspend or limit the license of any physician, surgeon or osteopathic physician or surgeon issued under this chapter upon satisfactory proof in compliance with chapter 1-26 of such a licensee's gross incompetence, or unprofessional or dishonorable conduct or proof of a violation of this chapter in any respect.

36-4-29.1. Summary suspension of license -- Hearing. If the state board of medical and osteopathic examiners finds that public health, safety or welfare imperatively require emergency action, and incorporates a finding to that effect in its order, or has information filed with the board that a licensee improperly obtained a license from the board, summary suspension of a license may be ordered pending final action by the board of examiners. The board of examiners shall convene a hearing within fifteen days of the effective date of the summary suspension and take action as provided in § 36-4-29.

36-4-30. Acts considered unprofessional conduct. The phrase "unprofessional or dishonorable conduct" as used in this chapter shall be construed to include:

(1) Producing or aiding or abetting a criminal abortion;

(2) Employing what is known as cappers or steerers;

(3) Obtaining any fee on the assurance that a manifestly incurable disease can be permanently cured;

(4) Willfully betraying a professional confidence;

(5) All advertising of medical business in which untruthful or improbable statements are made or which are calculated to mislead or deceive the public;

(6) Conviction of any criminal offense of the grade of felony, or any conviction of a criminal offense arising out of the practice of medicine or osteopathy, or one in connection with any criminal offense involving moral turpitude;

(7) Habits of intemperance, or drug addiction, calculated in the opinion of the board of medical and osteopathic examiners to affect the licensee's practice of his profession;

(8) Refusal or neglect to report the existence of a diseased or unsanitary condition to the proper health authorities, as prescribed by the regulations of such board;

(9) Prescribing intoxicants, narcotics, barbiturates or other habit-forming drugs, to any person in quantities and under circumstances making it apparent to the board that such prescription was not made for legitimate medicinal purposes or in a manner or in amounts, calculated in the opinion of the board to endanger the well-being of an individual patient or the public in general;

(10) Splitting fees or giving to any person furnishing a patient any portion of the fees received from such patient or paying or giving to any person any consideration whatsoever for furnishing any patient;

(11) Failure to disclose one's school of practice or one's professional academic degree when using a professional title or designation;

(12) Sustaining any physical or mental disability which renders the further practice of a licensee's profession dangerous;

(13) Failure to comply with state or federal laws relative to keeping records regarding possessing and dispensing of narcotics, barbiturates and habit-forming drugs;

(14) Falsifying the medical records of a patient, or any official record regarding possession and dispensing of narcotics, barbiturates and habit-forming drugs or regarding any phase of medical treatment of a patient;

(15) Presenting to the board any license, certificate or diploma which was obtained by fraud, or deception practiced in passing a required examination or which was obtained by the giving of false statements or information on applying for said license;

(16) Illegally or fraudulently or wrongfully obtaining a license required by this chapter, by the use of any means, devices, or deceptions or helps in passing any examination, or by making false statements or misrepresentations in any applications or information presented;

(17) Conviction of violating § 34-23A-10.1;

(18) Performing medical services which have been declared, by declaratory ruling of the board, to be of no medical value.

Conduct described in this section shall not be the basis for criminal prosecution unless otherwise declared unlawful.

36-4-31. Proceedings for cancellation, revocation or suspension of license. The proceedings for cancellation, revocation or suspension of a license shall be conducted in compliance with chapter 1-26.

36-4-31.1 to 36-4-31.3. Omitted.

36-4-31.4. Reissuance of canceled, suspended or revoked license. Upon application, the board of examiners may reissue a license to practice to any person whose license has been canceled, suspended or revoked. A reissuance of a license which has been canceled or revoked shall not be

STATE OF TENNESSEE
DEPARTMENT OF HEALTH AND ENVIRONMENT
BUREAU OF MANPOWER AND FACILITIES
HEALTH RELATED BOARDS
283 PLUS PARK BLVD.
NASHVILLE, TN 37219-5407

BOARD OF MEDICAL EXAMINERS

June 19, 1986

Minnesota Board of Medical Examiners
Suite 106
2700 University Ave. W.
St. Paul, MN 55114-1080

Attention: Fee Splitting Study

Gentlemen:

This will acknowledge receipt of your letter of May 21, 1986, concerning fee splitting.

Enclosed are copies of our Medical Practice Act, our Rules and Regulations, and the Division of Health Related Board law which governs all of the professions of the healing arts.

If we can be of further assistance, do not hesitate to contact us.

Sincerely,

Louise B. Blair

Louise B. Blair
Administrator

LBB/lg DD4

Enclosure

(b) Provided, however, that any recognized specialist in any brar healing arts, which special field is recognized by the appropr licensing that profession, may substitute the specialist designation for the words indicated hereinabove.

63-1-119. Collection of fees.- No fee for the issuance of licenses to practice the healing arts or any branch thereof shall be collected except by the appropriate board licensing that profession. The fees for certificates of annual registration required by the appropriate board licensing that profession shall be in addition to annual registration fees required by the Boards regulating the various branches of the healing arts. All fees due the Boards regulating the various branches of the healing arts shall be collected by the Division.

63-1-120. Disposition of Fines and Penalties (a) All fines and penalties, for offenses for the violation of this chapter shall be paid over to the Division of Health Related Boards, Department of Health and Environment, and shall become a part of the receipts of said Division. All money received by the Division shall be paid into the state treasury and become a part of the general fund of the state.

(b) The commissioner of finance and administration shall make such allotments out of the general fund as he may deem proper for the necessary expenses of all professional Boards for which fees are collected by the Division and no expenditure shall be made by the Division unless and until such allotment has been made by the commissioner. Such allotments shall be disbursed under the general budgetary laws of the state of Tennessee.

63-1-121. Repealed

63-1-122. Concurrent enforcement powers. The Division of Health Related Boards, Department of Health and Environment, in addition to the powers and duties vested in it by the foregoing sections of this chapter with respect to licensing and registration of practitioners of the various branches of the healing arts, shall have the power and duty to enforce the provisions of all regulatory laws now in force and designed to prevent unlawful practices within the state of the healing arts, but this power of enforcement shall not be exclusive in the Division of Health Related Boards, Department of Health and Environment, but shall be concurrent with the power now vested in various examining boards authorized to enforce compliance with the various laws regulating the practice of the healing arts, and nothing in this chapter shall be construed as limiting or repealing the power of the various examining boards to police and prosecute, in the manner provided by law, violations of any such regulatory statues.

63-1-123. Grounds for suspension or revocation of license. - The Division of Health Related Boards, Department of Health and Environment shall have the power, in addition to the powers provided to the boards for licensing the various branches of the healing arts in other chapters of this title, and it is its duty to suspend for a specified time to be determined in the discretion of the Division, or revoke any license to practice the healing arts or any branch thereof in the state of Tennessee whenever the licensee shall be found guilty of any of the following acts or offenses:

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(1) Fraud in procuring a license;
(2) Immoral, unprofessional, or dishonorable conduct;
(3) Habitual intoxication or addiction to or personal misuse of any drug;
(4) Conviction of a felony;
(5) Use of untruthful or misleading statements, or exaggerated or extravagant claims concerning such licensee's professional excellence or abilities;
(6) Willful violations of rules concerning the practice of the healing arts as defined in § 63-1-103, promulgated by the various boards of such healing arts to regulate advertising by practitioners of such healing arts;
(7) Distribution of intoxicating liquors or drugs for any other than lawful purposes;
(8) Willful or repeated violation of this chapter or the rules and regulations of the department of Health and Environment governing the control of communicable diseases;
(9) Willful violation of federal or state drug laws;
(10) Unlawful invasion of the field of practice of any profession mentioned in this chapter which the licensee is not licensed to practice;
(11) Solicitation by agents or persons popularly known as "cappers" or "steerers", of professional patronage or profiting by the acts of those representing themselves to be agents of the licensee;
(12) Division of fees or agreeing to split or divide the fees received for professional services with any person for bringing or referring a patient;
(13) The use of any letters, words, term or terms, either as a prefix, affix, or suffix, on stationery, in advertisements, or otherwise, indicating that such person is entitled to practice a system or mode of healing for which he is not licensed;
(14) Performing, procuring, or aiding and abetting in the performance of a criminal abortion;
(15) Willful betrayal of a professional secret;
(16) Making use of any advertising statements of a character tending to deceive or mislead the public;
(17) Advertising any free professional services or free examinations;
(18) Offering discounts or inducements to prospective patients by means of coupons or otherwise to perform professional services during any period of time for a lesser or more attractive price; or
(19) Continuing to practice after suspension or revocation of certificate of fitness by the appropriate examining board.

63-1-124. Repealed

63-1-125. Proceedings to enjoin violations.- The Division of Health Related Boards, Department of Health and Environment, in addition to the powers and duties expressed in this chapter with respect to the denial of a license, denial of certificate of registration and suspension or revocation of a license, is empowered to petition any circuit or chancery court having jurisdiction of any person within this state, who is practicing without a license or to whom a license has been

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(b) Each person licensed to practice medicine and surgery in this state shall annually on or before the 31st day of December on each succeeding year apply to the state board of medical examiners for a renewal of his license and shall pay a renewal fee not to exceed twenty-five ($25.00) as set annually by the board. Each application shall be made on a form to be furnished by the board. The state board of medical examiners shall in its discretion renew such license upon application made in due form and upon payment of all required fees.

(c) When any such person shall fail to renew his license and pay the annual renewal fee after renewal becomes due, the license of such person shall be automatically revoked without further notice or hearing unless renewal is made and all fees paid prior to the expiration of sixty (60) days from the date such renewal becomes due. Any person whose license is automatically revoked as provided herein may have his license reinstated by the board in its discretion upon good cause being shown and upon payment of all past due renewal fees and upon the further payment of the sum of fifty dollars ($50.00), which sum may be used by the board in the investigation of such applicant.

63-6-211. Reciprocity.- (a) The board is permitted to accept certificates of license from other states requiring the same or higher standards of medical examinations in lieu of an examination, but as to the matter of reciprocity of licensure, the board shall be the sole judge. The fees for verifying certificates of license from other states and issuing certificates of fitness to applicants shall be an amount not to exceed two hundred fifty dollars ($250) for each license so verified and certificate issued thereon.

(b) The board is likewise authorized to accept a certificate diploma of the national board of medical examiners in lieu of an examination and may issue a certificate of fitness thereon upon the payment of a fee in an amount not to exceed two hundred fifty dollars ($250).

63-6-212. Records.- The board of examiners shall keep a record of their proceedings in a book provided for that purpose, which book shall be open for inspection, and shall record the name of each applicant, the time of granting a license, and the names of the members of the board present; and where a license is denied by the board to any applicant under authority of this chapter, the fact and ground of such denial shall be entered on the minutes of the board, and shall be communicated in writing to such applicant.

63-6-213. Investigation and prosecution of violations.- The members of the board of medical examiners shall investigate any supposed violation of this chapter and report to the proper district attorney general all the cases that in the judgement of such member or members warrant prosecution. It shall be the duty of the attorney general of the several districts to prosecute violators of this chapter.

63-6-214. Grounds for license denial or suspension- Reporting misconduct.- (a) The board shall have the power to deny an application for a license to any applicant who applies for the same through reciprocity or otherwise; to permanently or temporarily withhold issuance of a license; to suspend or limit or resrict a previously issued license for such time and in such manner as the board may determine; to reprimand or take such action in relation to disciplining an applicant

or licensee as the board in its discretion may deem proper; or to permanently revoke a license. The grounds upon which the board shall exercise such power includes, but is not limited to, the following:

(1) Unprofessional, dishonorable, or unethical conduct;

(2) Violation or attempted violation, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter or any lawful order of the board issued pursuant thereto, or any criminal statute of the state of Tennessee;

(3) Making false statements or representations, being guilty of fraud or deceit in obtaining admission to practice, or in being guilty of fraud or deceit in the practice of medicine;

(4) Gross malpractice, or a pattern of continued or repeated malpractice, ignorance, negligence or incompetence in the course of medical practice;

(5) Habitual intoxication or personal misuse of any drugs or the use of intoxicating liquors, narcotics, controlled substances, or other drugs or stimulants in such manner as to adversely affect the person's ability to practice medicine;

(6) Violation of the laws governing abortion;

(7) Willfully betraying a professional secret;

(8) The advertising of medical business in which untrue or misleading statements are made, or causing the publication or circulation of fraudulent advertising relative to any disease, human ailment, or conditions;

(9) Willful violation of the rules and regulations promulgated by the board of medical examiners to regulate advertising by practitioners who are under the jurisdiction of such board;

(10) Conviction of a felony, conviction of any offense under state or federal drug laws, or conviction of any offense involving moral turpitude;

(11) Making or signing in one's professional capacity any certificate that is known to be false at the time one makes or signs such certificate;

(12) Dispensing, prescribing, or therwise distributing any controlled substance or any other drug not in the course of professional practice, or not in good faith to relieve pain and suffering, or not to cure an ailment, physical infirmity or disease;

(13) Dispensing, prescribing, or otherwise distributing to any person a controlled substance or other drug if such person is addicted to the

TN.

habit of using said controlled substances without making a bona fide effort to cure the habit of such patient;

(14) Dispensing, prescribing, or otherwise distributing any controlled substance or other drug to any person in violation of any law of the state or of the United States of America;

(15) Offering, undertaking, or agreeing to cure or treat a disease, injury, ailment or infirmity by a secret means, method, device or instrumentality;

(16) Giving or receiving, or aiding or abetting the giving or receiving or rebates, either directly or indirectly;

(17) Engaging in the practice of medicine under a false or assumed name, or the impersonation of another practitioner, or a like, similar or different name; and

(18) Engaging in the practice of medicine when mentally or physically unable to safely do so.

(b) In enforcing this section, the board shall upon probable cause, have authority to compel an applicant or licensee to submit to a mental and/or physical examination by a designated committee of at least three (3) practicing physicians, including a psychiatrist where a question of mental condition is involved. The applicant or licensee may have an independent medical practitioner present during such examination, and he may have an independent physical or mental examination which examination report shall be filed with the board for consideration. The committee will submit a report of its findings to the board which will then hold a hearing as provided in § 63-6-216.

(c) The board on its own motion may investigate any report indicating that a doctor of medicine is or may be in violation of the provisions of subsection (a) hereof. Any doctor of medicine, any medical society or any other person who in good faith shall report to the board any information that a doctor of medicine is or may be in violation of any of the provisions of subsection (a) hereof shall not be subject to suit for civil damages as a result thereof.

(d) Within thirty (30) days after the conviction of a person known to be a physician, licensed or otherwise lawfully practicing within this state or applying to be so licensed or to practice, of a felony under the laws of this state, the clerk of the court of record in which the conviction was entered shall prepare and forward to the board a certified true and correct abstract of record of the court governing the case. The abstract shall include the name and address of the physician or applicant, the nature of the offense committed, the sentence, and the judgment of the court. The board shall prepare the form of the abstract and shall distribute copies thereof to all clerks of courts of record within this state with appropriate instruction for preparation and filing.

(e) The board shall report within sixty (60) days its action regarding restriction, suspension, or revocation of a physician's license, limitation on practice privileges,

TN.

Minnesota Board of Medical Examiners

EXECUTIVE OFFICE
Suite 106
2700 University Avenue West
St. Paul, Minnesota 55114-1080
(612) 642-0538

May 21, 1986

Wrong enclosure?

Vermont Board of Medical Practice
Mrs. Carol Fleury
Licensing & Registration
Pavilion Bldg, 109 State St.
Montpelier, VT 05602

Dear Mrs. Fleury:

The Minnesota Board of Medical Examiners is in the process of gathering information prior to promulgating administrative rules on fee splitting.

To assist us in this process we request that you send us copies of any statute, administrative rules, or policy statement your Board has on this topic.

Please send these to:

Minnesota Board of Medical Examiners
Suite 106
2700 University Ave. W.
St. Paul, MN 55114-1080
Attention: Fee Splitting Study

If you have any questions or if I can be of assistance to you in responding please contact me at the above address or at (612) 642-0598.

Thank you for your cooperation.

Sincerely,

Richard L. Auld

Richard L. Auld
Assistant Executive Director

AN EQUAL OPPORTUNITY EMPLOYER

RULES ON RULEMAKING
OFFICE OF THE SECRETARY OF STATE

May 1985

Section 1. Introduction.

These rules are required by 3 V.S.A. § 847(e) for the effective adminstration of Chapter 25 of Title 3. They apply to every agency of state government adopting rules under the APA. For a fuller understanding of the rulemaking process, you must consult 3 V.S.A. §§ 801 - 849 and the rules of the Legislative Committee on Administrative Rules.

Section 2. Filings.

The APA requires agencies to make filings of every new, amended or repealed rule at least three times during the promulgation process, viz., a proposed rule, to begin the adoption process; a final proposal, to signal the end of the notice period and the involvement of the legislative committee on administrative rules; and an adopted rule, to begin the minimum 15 day period prior the effective date of the rules. In each case, agencies must use the forms provided by the secretary of state for that purpose. These forms are incorporated as part of this rule. They include:

1. Proposed Rule: Cover Sheet
2. Final Proposal: Cover Sheet
3. Adopted Rule: Cover Sheet
4. Economic Impact Statement
5. Incorporation by Reference Statement
6. Emergency Rule: Cover Sheet
7. Adopting Page

If the secretary of state finds that the filings are sufficient, the rule is stamped with the date and time and filed. If the filings are inadequate, the secretary of state will contact the agency immediately. In particular, the secretary of state will consult with the agency prior to editing the Concise Summary of any rule, prior to publication. Material in addition to forms must be submitted on 8 1/2" by 11" paper.

In addition to the appropriate forms, an agency must also file a copy of the text of the proposed or adopted rule and an annotated text showing changes from existing rules. To satisfy the requirement for an annotated text, an agency must submit the entire rule in annotated form with the filings of proposed rules and final proposals. Filing a paragraph or page of a larger rule is not sufficient. As an alternative, if the rules of the agency have been published as part of the Vermont Administrative Code (VAC), the agency must file the annotated text, if possible, using the appropriate page or pages of the VAC as a basis for the annotated version. New rules need not be accompanied by an annotated text. Rules which have been comprehensively revised are also exempted from the requirement for an annotated text, although a copy of the former rule is required.

Whenever an agency intends to adopt rules by incorporation by reference, a copy of all rules so adopted must be filed with the appropriate forms when the

rule is first filed in its proposed form. If the incorporation by reference materials are not amended or changed before the filing of the final proposal or the filing of the adopted rule and the agency so certifies this fact to the secretary of state, no additional filing of incorporated materials will be required.

Section 3. Publication and Public Notice.

Completed filings of proposed rules received by Friday at 4:30 p.m. will be published 13 and 20 days after that date, in the regular advertisements in the various daily and weekly newspapers of record.

The first of the two published notices is the longer version of the advertisement, and includes the date, time and place of the hearing and the deadline for receiving comments. This information is often not known to the agency prior to publication or must be changed as a result of later events. When the agency learns of the need for a new hearing date or for an extension of the public comment period, the agency must arrange for publication of notice of this new information by mailing individual notice to each person who has contacted the agency about the rule and to the major news services.

When no public hearing has been called or set in the first advertisement, agencies often wonder what date to use as a deadline for public comment on a proposed rule. The secretary of state recommends that agencies set deadlines for public comment no less than two full weeks following the publication of the second advertisement. If an agency then receives a petition for a public hearing, or decides to hold a hearing on its own motion, the deadline for public comment must then by law be reestablished on a date no less than seven days following the last public hearing.

Agencies filing proposed rules with the secretary of state must share the costs of advertisements with other agencies publishing at the same time. The secretary of state will compute the cost of each agency's prorated share of these expenses by allocating an equal share of the total cost of the appropriate week's advertising to each participating agency.

COMMONWEALTH of VIRGINIA

Department of Health Regulatory Boards
Board of Medicine

BERNARD L. HENDERSON, JR.
DIRECTOR

GEORGE J. CARROLL, M.D.
SECRETARY-TREASURER

EUGENIA K. DORSON
EXECUTIVE SECRETARY

517 WEST GRACE STREET
POST OFFICE BOX 27708
RICHMOND, VIRGINIA 23261
(804) 786-0575

May 28, 1986

Richard L. Auld
Assistant Executive Director
Minnesota Board of Medical Examiners
Suite 106
2700 University Avenue West
St. Paul, Minnesota 55114-1080

Dear Mr. Auld:

In response to the issue of fee splitting, enclosed is a current copy of the Laws of Virginia Relating to Medicine and Other Healing Arts. Your attention is directed to Section 54-278 which is the only reference that address the fee splitting issue directly. However, Section 54-317 "What constitutes unprofessional conduct", can be utilized for such activities.

Should the Minnesota Board develop such rules and code sections, it is requested that they be shared with the Virginia Board of Medicine.

Also, I wish to express our appreciation for the outstanding reception and hospitality shown during the Federation meeting to all of us who were in attendance.

Sincerely,

Eugenia K. Dorson

Eugenia K. Dorson,
Executive Secretary
Virginia Board of Medicine

EKD:laf

Enclosure

§ 54-276.11. Physicians may give information about certain handicapped persons to appropriate public agencies. — Nothing in this chapter or any other law of Virginia shall be construed to prohibit any duly licensed physician from communicating the identity of any person under age twenty-two who has a physical or mental handicapping condition to appropriate agencies of the Commonwealth or any of its political subdivisions and other information regarding such person or condition which may be helpful to the agency in the planning or conduct of services for handicapped persons. (1972, c. 431.)

§ 54-276.12: Repealed by Acts 1983, c. 25.

Cross reference. — For exemption from liability of health care professionals rendering services at free clinics, see now § 54-1.2:2.

§ 54-277: Repealed by Acts 1954, c. 626.

§ 54-278. Division of fees between physicians and surgeons prohibited. — No surgeon or physician shall directly or indirectly share any fee charged for a surgical operation or medical services with a physician who brings, sends or recommends a patient to such surgeon for operation, or such physician for such medical services; and no physician who brings, sends, or recommends any patient to a surgeon for a surgical operation or medical services shall accept from such surgeon or physician any portion of a fee charged for such operation; provided, however, that nothing in this chapter shall be construed as prohibiting the members of any regularly organized partnership of such surgeons or physicians from making any division of their total fees among themselves as they may determine or a group of duly licensed practitioners of any branch or branches of the healing arts from using their joint fees to defray their joint operating costs. Any person violating the provisions of this section shall be guilty of a misdemeanor. (Code 1919, § 1639; 1928, p. 1358; 1956, c. 389.)

§ 54-278.1. Practicing medicine in connection with commercial or mercantile establishment. — It shall be unlawful for any physician to practice his profession as a lessee of any commercial or mercantile establishment, or to advertise, either in person or through any commercial or mercantile establishment, that he is a duly registered practitioner and is practicing or will practice medicine, as a lessee of any such commercial or mercantile establishment. But nothing herein shall be construed to prohibit or prevent the rendering of professional services to the officers and employees of any person, firm or corporation by a physician, whether or not the compensation for such service is paid by the officers and employees, or by the employer, or jointly by all or any of them. Any physician who shall violate any of the provisions of this section shall be guilty of a misdemeanor and punished accordingly. (1948, p. 442; Michie Suppl. 1948, § 1639a.)

§ 54-278.2. Selling vitamins or food supplements in connection with a practice of the healing arts. — The Board shall have authority to

Applied in Health Systems Agency v. Virginia State Bd. of Medicine, 424 F. Supp. 267 (E.D. Va. 1976).

§ 54-317. What constitutes unprofessional conduct. — Any practitioner of medicine, osteopathy, chiropractic, podiatry, physical therapy or clinical psychology or any physical therapist assistant shall be considered guilty of unprofessional conduct if he:

(1) Undertakes or engages in any manner or by any means whatsoever to procure or perform or to aid or abet in procuring or performing a criminal abortion; or

(2) Engages in the practice of any of the healing arts under a false or assumed name, or impersonates another practitioner of a like, similar or different name; or

(3) Prescribes or dispenses any controlled substance with intent or knowledge that it shall or will be used otherwise than medicinally, or for accepted therapeutic purposes, or with intent to evade any law with respect to the sale, use or disposition of such drug; or

(4) [Repealed.]

(5) Causes the publication or circulation or broadcasting of any advertisement or statement in which he claims that he can cure or treat diseases, ailments or infirmities by any secret method, procedure, treatment or medicine, or in which he claims that a manifestly incurable disease or infirmity can be permanently cured; or

(6) Advertises or professes or holds himself out as being able and willing to treat human ailments under a system or school of practice other than that for which he holds a certificate or license granted by the Board; or

(7) Violates any of the provisions of § 54-278 or practices any branch of the healing arts in violation of the provisions of this chapter; or

(8) Being a practitioner of physical therapy, undertakes to practice physical therapy, independently of the referral and direction of a duly licensed doctor of medicine, or osteopathy; or being a licensed physical therapist assistant, undertakes to practice independently without direction of a physical therapist or under his supervision or control; or

(9) Knowingly and willfully commits any act which is a felony under the laws of this Commonwealth or of the United States, or any act which is a misdemeanor under such laws and involves moral turpitude; or

(10) Aids or abets, has professional connection with, or lends his name to any person known to him to be practicing illegally any of the healing arts; or

(11) Conducts his practice in a manner contrary to the standards of ethics of his branch of the healing arts or in such a manner as to make his practice a danger to the health and welfare of his patient or to the public; or is unable to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, excessive use of drugs, narcotics, chemicals or any other type of material or as a result of any mental or physical condition. In enforcing this subsection, the Board shall upon probable cause, and upon preliminary investigation by informal conference as provided in § 54-318.1, have authority to compel a practitioner to submit to a mental or physical examination by physicians designated by it. Failure of a practitioner to submit to such examination when directed shall constitute an admission of the allegations against him, unless the failure was due to circumstances beyond his control, consequent upon which a default and final order may be

entered without the taking of testimony or presentation of evidence. A physician affected under this subsection shall, at reasonable intervals, be afforded an opportunity to demonstrate that he can resume the competent practice of medicine with reasonable skill and safety to patients; or

(12) Being a practitioner of the healing arts who may lawfully dispense, administer, or prescribe, medicines or drugs, and not being the holder of a certificate of registration to practice pharmacy, engages in selling medicine, drugs, eyeglasses, or medical appliances or devices to persons who are not his own patients, or sells such articles to his own patients either for his own convenience, or for the purpose of supplementing his income; provided, however, that the dispensing of contact lenses by a practitioner to his patients shall not be deemed to be for the practitioner's own convenience or for the purpose of supplementing his income; or

(13) Publishes or causes to be published in any manner an advertisement relating to his professional practice which (i) is false, deceptive or misleading, (ii) contains a claim of superiority, or (iii) violates such regulations as may be promulgated by the Board governing advertising; or

(14) Performs any dishonorable, unethical, unprofessional or unconscionable conduct likely to deceive, defraud or harm the public; or

(15) Violates any provision of law or regulation, state or federal, relating to the manufacture, distribution, dispensing or administration of drugs; or

(16) Violates or cooperates with others in violating any of the provisions of this chapter or regulations of the Board. (1944, p. 278; Michie Suppl. 1946, § 1619; 1954, c. 627; 1958, c. 161; 1966, cc. 166, 657; 1968, c. 582; 1970, c. 69; 1973, c. 529; 1975, c. 508; 1978, c. 622; 1979, c. 727; 1980, c. 157; 1985, c. 96.)

The 1985 amendment substituted "therapist" for "therapy" in the introductory paragraph and in subdivision (8) and substituted "Commonwealth" for "State" in subdivision (9).

Law Review. — For a survey of developments in Virginia constitutional law for the year 1973-1974, see 60 Va. L. Rev. 1490 (1974).

Former provision prohibiting advertising held unconstitutional. — Since subdivision (13) of this section as it stood before the 1978 amendment did not prevent physicians from giving prospective patients the same information the subdivision proscribed in advertisements, the section could not be sustained on the basis that it was designed to prevent deceptive advertising. The protection of the public from fraud and deception must rest on other provisions in the statute. Therefore, the State's interest in prohibiting false and deceptive advertising by physicians did not justify the broad restrictions that former subdivision (13) imposed. Health Systems Agency v. Virginia State Bd. of Medicine, 424 F. Supp. 267 (E.D. Va. 1976).

Subdivision (13) of this section as it stood before the 1978 amendment abridged the plaintiffs' First Amendment rights to gather, publish and receive information about physicians' services in the manner proposed by the plaintiff agency through the publication of its directory. Health Systems Agency v. Virginia State Bd. of Medicine, 424 F. Supp. 267 (E.D. Va. 1976).

Applied in Simopoulos v. Virginia State Bd. of Medicine, 644 F.2d 321 (4th Cir. 1981).

STATE OF WASHINGTON
DEPARTMENT OF LICENSING
Highways-Licenses Building • Olympia, Washington 98504 • (206) 753-6918
Theresa Anna Aragón, *Director*

July 15, 1986

Minnesota Board of Medical Examiners
Suite 106
2700 University Ave. W.
St. Paul, MN 55114-1080

Dear Sir:

We have received your request for information as to our State Board policy and statutes concerning Fee Splitting.

We have enclosed a copy of our State RCW's pertaining to this request. We hope this has been helpful.

If you have questions or are in need of assistance, please contact this office.

Sincerely,

Linda Lenz

Linda Lenz
Clerk-Typist
Medical Disciplinary Board
Division of Professional Licensing
P.O. Box 9649
Olympia, WA 98504
(206) 753-2205

19.62.900 Severability——1979 ex.s. c 107. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected. [1979 ex.s. c 107 § 3.]

Chapter 19.64
RADIO BROADCASTING

Sections

19.64.010 Liability of owner or operator limited.
19.64.020 Speaker or sponsor liability not limited.
19.64.900 Saving——1943 c 229.

Libel and slander: Chapter 9.58 RCW.

Radio broadcasting rights as to horse races: RCW 67.16.110.

19.64.010 Liability of owner or operator limited. Where the owner, licensee, or operator of a radio or television broadcasting station, or the agents or employees thereof, has required a person speaking over said station to submit a written copy of his script prior to such broadcast and has cut such speaker off the air as soon as reasonably possible in the event such speaker deviates from such written script, said owner, licensee, or operator, or the agents or employees thereof, shall not be liable for any damages, for any defamatory statement published or uttered by such person in or as a part of such radio or television broadcast unless such defamatory statements are contained in said written script. [1943 c 229 § 1; Rem. Supp. 1943 § 998–1.]

19.64.020 Speaker or sponsor liability not limited. Nothing contained shall be construed as limiting the liability of any speaker or his sponsor or sponsors for defamatory statements made by such speaker in or as a part of any such broadcast. [1943 c 229 § 2; Rem. Supp. 1943 § 998–2.]

19.64.900 Saving——1943 c 229. This chapter shall not be applicable to or affect any cause of action existing at the time this chapter becomes effective. [1943 c 229 § 3.]

Chapter 19.68
REBATING BY PRACTITIONERS OF HEALING PROFESSIONS

Sections

19.68.010 Rebating prohibited——Penalty.
19.68.020 Deemed unprofessional conduct.
19.68.030 License may be revoked or suspended.
19.68.040 Declaration of intent.

Hearing aid fitter–dispensers: RCW 18.35.110.

Physicians, surgeons, dentists, oculists, optometrists, osteopaths, chiropractors, drugless healers, etc.: Title 18 RCW.

Revocation, suspension, denial of podiatrist's license——Unprofessional conduct as grounds——Scope: RCW 18.22.151.

19.68.010 Rebating prohibited——Penalty. It shall be unlawful for any person, firm, corporation or association, whether organized as a cooperative, or for profit or nonprofit, to pay, or offer to pay or allow, directly or indirectly, to any person licensed by the state of Washington to engage in the practice of medicine and surgery, drugless treatment in any form, dentistry, or pharmacy and it shall be unlawful for such person to request, receive or allow, directly or indirectly, a rebate, refund, commission, unearned discount or profit by means of a credit or other valuable consideration in connection with the referral of patients to any person, firm, corporation or association, or in connection with the furnishings of medical, surgical or dental care, diagnosis, treatment or service, on the sale, rental, furnishing or supplying of clinical laboratory supplies or services of any kind, drugs, medication, or medical supplies, or any other goods, services or supplies prescribed for medical diagnosis, care or treatment: *Provided*, That ownership of a financial interest in any firm, corporation or association which furnishes any kind of clinical laboratory or other services prescribed for medical, surgical, or dental diagnosis shall not be prohibited under this section where the referring practitioner affirmatively discloses to the patient in writing, the fact that such practitioner has a financial interest in such firm, corporation, or association.

Any person violating the provisions of this section is guilty of a misdemeanor. [1973 1st ex.s. c 26 § 1; 1965 ex.s. c 58 § 1. Prior: 1949 c 204 § 1; Rem. Supp. 1949 § 10185–14.]

19.68.020 Deemed unprofessional conduct. The acceptance directly or indirectly by any person so licensed of any rebate, refund, commission, unearned discount, or profit by means of a credit or other valuable consideration whether in the form of money or otherwise, as compensation for referring patients to any person, firm, corporation or association as set forth in RCW 19.68-.030, constitutes unprofessional conduct. [1965 ex.s. c 58 § 2; 1949 c 204 § 2; Rem. Supp. 1949 § 10185–15.]

19.68.030 License may be revoked or suspended. The license of any person so licensed may be revoked or suspended if he has directly or indirectly requested, received or participated in the division, transference, assignment, rebate, splitting or refunding of a fee for, or has directly or indirectly requested, received or profited by means of a credit or other valuable consideration as a commission, discount or gratuity in connection with the furnishing of medical, surgical or dental care, diagnosis or treatment or service, including x–ray examination and treatment, or for or in connection with the sale, rental, supplying or furnishing of clinical laboratory service or supplies, x–ray services or supplies, inhalation therapy service or equipment, ambulance service, hospital or medical supplies, physiotherapy or other therapeutic service or equipment, artificial limbs, teeth or eyes, orthopedic or surgical appliances or supplies, optical appliances, supplies or equipment, devices for aid of hearing, drugs, medication or medical supplies or any other goods, services or supplies prescribed for medical diagnosis, care or treatment, except payment, not to exceed thirty–three and one–third percent of any fee received

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for x-ray examination, diagnosis or treatment, to any hospital furnishing facilities for such examination, diagnosis or treatment. [1965 ex.s. c 58 § 3. Prior: 1949 c 204 § 3; Rem. Supp. 1949 § 10185-16.]

19.68.040 Declaration of intent. It is the intent of this article [chapter], and this article [chapter] shall be so construed, that persons so licensed shall only be authorized by law to charge or receive compensation for professional services rendered if such services are actually rendered by the licensee and not otherwise: *Provided, however,* That it is not intended to prohibit two or more licensees who practice their profession as copartners to charge or collect compensation for any professional services by any member of the firm, or to prohibit a licensee who employs another licensee to charge or collect compensation for professional services rendered by the employee licensee. [1949 c 204 § 4; Rem. Supp. 1949 § 10185-17.]

Chapter 19.70
RIFLES AND SHOTGUNS

Sections

19.70.010 Out-of-state purchasing authorized.
19.70.020 Purchasing by nonresidents authorized.

Firearms and dangerous weapons: Chapter 9.41 RCW.

19.70.010 Out-of-state purchasing authorized. Residents of Washington may purchase rifles and shotguns in a state other than Washington: *Provided,* That such residents conform to the applicable provisions of the federal Gun Control Act of 1968, Title IV, Pub. L. 90-351 as administered by the United States secretary of the treasury: *And provided further,* That such residents are eligible to purchase or possess such weapons in Washington and in the state in which such purchase is made. [1970 ex.s. c 74 § 1.]

19.70.020 Purchasing by nonresidents authorized. Residents of a state other than Washington may purchase rifles and shotguns in Washington: *Provided,* That such residents conform to the applicable provisions of the federal Gun Control Act of 1968, Title IV, Pub. L. 90-351 as administered by the United States secretary of the treasury: *And provided further,* That such residents are eligible to purchase or possess such weapons in Washington and in the state in which such persons reside. [1970 ex.s. c 74 § 2.]

Chapter 19.72
SURETYSHIP

Sections

19.72.001 Definitions.
19.72.020 Individual sureties——Eligibility.
19.72.030 Individual sureties——Number——Qualification.
19.72.040 Individual sureties——Examination——Approval.
19.72.060 Corporate surety.
19.72.070 Subrogation of surety.
19.72.080 Contribution among sureties.

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the rights or privileges conferred by any license or certificate granted by the board unless currently registered as required under this subsection.

(b) On or before March 10 of each even-numbered year the board shall publish the register required by s. 440.035 (4), which shall be divided according to the activity for which the registrant is licensed or certified. The secretary of the board shall cause a copy of the list to be mailed to the secretary of state, the district attorney of each county, each local board of health, the sheriff of each county, the chief of police of each community and to any other public official who may request or have need thereof. The board shall make copies available for general distribution at cost.

(c) Every registration made as provided in this section shall be presumptive evidence in all courts and other places that the person named therein is legally registered for the period covered by such registration, and shall be deemed to fulfill any statutory requirement for renewal of license or certificate.

(d) No registration may be permitted by the secretary of the board in the case of any physician who has failed to meet the requirements of s. 448.13 or any person whose license or certificate has been suspended or revoked and the registration of any such person shall be deemed automatically annulled upon receipt by the secretary of the board of a verified report of such suspension or revocation, subject to the licensee's right of appeal. A person whose license or certificate has been suspended or revoked and subsequently restored shall be registered by the board upon tendering a verified report of such restoration of the license or certificate, together with an application for registration and the registration fee.

(e) If any person licensed or certified under this chapter fails to register as required for 3 consecutive years, the board may require such person to demonstrate to the satisfaction of the board fitness to practice under such license or certificate before permitting such person to be reregistered.

(2) FEES. The fees for examination and licenses granted or renewed under this chapter are specified in s. 440.05.

History: 1975 c. 383, 421; 1977 c. 29, 131, 418; 1979 c. 162

448.08 Fee splitting; separate billing required, partnerships and corporations; contract exceptions. (1) FEE SPLITTING. Except as otherwise provided in this section, no person licensed or certified under this chapter may give or receive, directly or indirectly, to or from any person, firm or corporation any fee, commission, rebate or other form of compensation or anything of value for sending, referring or otherwise inducing a person to communicate with a licensee in a professional capacity, or for any professional services not actually rendered personally or at his or her direction.

(2) SEPARATE BILLING REQUIRED. Any person licensed under this chapter who renders any medical or surgical service or assistance whatever, or gives any medical, surgical or any similar advice or assistance whatever to any patient, physician or corporation, or to any other institution or organization of any kind, including a hospital, for which a charge is made to such patient receiving such service, advice or assistance, shall, except as authorized by Title 18 or Title 19 of the federal social security act, render an individual statement or account of the charges therefor directly to such patient, distinct and separate from any statement or account by any physician or other person, who has rendered or who may render any medical, surgical or any similar service whatever, or who has given or may give any medical, surgical or similar advice or assistance to such patient, physician, corporation, or to any other institution or organization of any kind, including a hospital.

(3) BILLING FOR TESTS PERFORMED BY THE STATE LABORATORY OF HYGIENE. A person other than a state or local government agency who charges a patient, other person or 3rd party payer for services performed by the state laboratory of hygiene shall identify the actual amount charged by the state laboratory of hygiene and shall restrict charges for those services to that amount.

(4) PROFESSIONAL PARTNERSHIPS AND CORPORATIONS PERMITTED. Notwithstanding any other provision in this section, it is lawful for 2 or more physicians, 2 or more podiatrists or 2 or more physical therapists, who have entered into a bona fide partnership for the practice of medicine, podiatry or physical therapy, to render a single bill for such services in the name of such partnership; and it also is lawful for a service corporation of physicians, podiatrists or physical therapists to render a single bill for such services in the name of the corporation; provided that each individual physician, podiatrist or physical therapist rendering services so billed for shall be individually identified as having rendered such services.

(5) CONTRACT EXCEPTIONS; TERMS. Notwithstanding any other provision in this section, when a hospital and its medical staff or a medical education and research organization and its medical staff consider that it is in the public interest, a physician may contract with the hospital or organization as an employe or to

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provide consultation services for attending physicians as provided in this subsection.

(a) Contracts under this subsection shall:

1. Require the physician to be a member of or acceptable to and subject to the approval of the medical staff of the hospital or medical education and research organization.

2. Permit the physician to exercise professional judgment without supervision or interference by the hospital or medical education and research organization.

3. Establish the remuneration of the physician.

(b) If agreeable to the contracting parties, the hospital or medical education and research organization may charge the patient for services rendered by the physician, but the statement to the patient shall indicate that the services of the physician, who shall be designated by name, are included in the departmental charges.

(c) No hospital or medical education and research organization may limit staff membership to physicians employed under this subsection.

(d) The responsibility of physician to patient, particularly with respect to professional liability, shall not be altered by any employment contract under this subsection.

(6) DEFINITIONS. As used in this section:

(a) "Hospital" means an institution providing 24-hour continuous service to patients confined therein which is primarily engaged in providing facilities for diagnostic and therapeutic services for the surgical and medical diagnosis, treatment and care, of injured or sick persons, by or under the supervision of a professional staff of physicians and surgeons, and which is not primarily a place of rest for the aged, drug addicts or alcoholics, or a nursing home. Such hospitals may charge patients directly for the services of their employe nurses, nonphysician anesthetists, physical therapists and medical assistants other than physicians or dentists, and may engage on a salary basis interns and residents who are participating in an accredited training program under the supervision of the medical staff, and persons with a temporary educational certificate issued under s. 448.04 (1) (c).

(b) "Medical education and research organization" means a medical education and medical research organization operating on a nonprofit basis.

History: 1975 c. 383, 421; 1977 c. 29.

Medical professional service corporation may bill patient for services by both physician and physical therapist if billing separates charges. OAG 31-82.

448.09 Penalties; appeal. (1) PENALTIES. Anyone violating s. 448.08 (3) may be fined not more than $250. Anyone violating any other provision of this chapter may be fined not more than $10,000 or imprisoned not more than 9 months or both.

(2) APPEAL. Any person aggrieved by any action taken under this chapter by the board, its officers or its agents may apply for judicial review as provided in ch. 227, and shall file notice of such appeal with the secretary of the board within 30 days. No court of this state may enter an ex parte stay of any action taken by the board under this chapter.

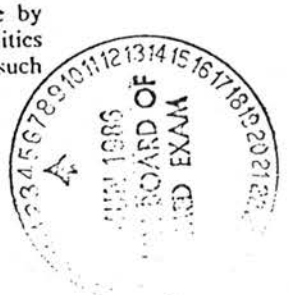
History: 1975 c. 383; 1977 c. 29.

448.10 Previous practice. (1) OSTEOPATHY. Sections 448.02 (1), 448.03 (1) and (3), 448.04 and 448.05 shall not be construed to abrogate the existing rights, privileges and immunities of any person licensed to practice osteopathy and surgery, or osteopathy, who does not hold license to practice medicine and surgery.

(2) PODIATRY. Any person lawfully practicing podiatry in this state under a certificate of registration granted under s. 448.13, 1973 stats., may continue to so practice until one year after June 15, 1976, and may apply for and be granted a license to practice podiatry without further examination and without payment of an additional fee, provided that such application is made to the board within one year after June 15, 1976.

(3) PHYSICAL THERAPY. Any person lawfully practicing physical therapy in this state under a certificate of registration granted under s. 448.09, 1973 stats., may continue so to practice until one year from June 15, 1976, and may apply for and be granted a license to practice physical therapy without further examination and without payment of an additional fee, provided that such application is made to the board within one year after June 15, 1976.

(4) MASSAGE AND HYDROTHERAPY. Any person who, on July 11, 1953, was practicing massage and hydrotherapy in this state under a certificate of registration issued pursuant to s. 147.185, 1951 stats. as it existed prior to July 11, 1953, or who had applied for a certificate of registration in massage and hydrotherapy before said date, shall have the right to continue to so practice under such certificate, and the term "massage and hydrotherapy" shall be deemed to include the use of galvanic generator, diathermy, infrared ray and ultraviolet light for massage purposes. Nothing contained in this subsection shall limit the existing authority of the board to revoke such certificate for cause, and in addition, the board may require the holder of such certificate to demonstrate by examination fitness to use the instrumentalities enumerated in this subsection. A lack of such



Minnesota Board of Medical Examiners

EXECUTIVE OFFICE
Suite 106
2700 University Avenue West
St. Paul, Minnesota 55114-1080
(612) 642-0538



May 21, 1986

Wyoming Board of Medical Examiners
Lawrence J. Cohen, M.D., Executive Secretary
Hathaway Bldg.
4th Floor
Cheyenne, WY 82002

Dear Dr. Cohen:

The Minnesota Board of Medical Examiners is in the process of gathering information prior to promulgating administrative rules on fee splitting.

To assist us in this process we request that you send us copies of any statute, administrative rules, or policy statement your Board has on this topic.

Please send these to:

Minnesota Board of Medical Examiners
Suite 106
2700 University Ave. W.
St. Paul, MN 55114-1080
Attention: Fee Splitting Study

If you have any questions or if I can be of assistance to you in responding please contact me at the above address or at (612) 642-0598.

Thank you for your cooperation.

Sincerely,

Richard L. Auld

Richard L. Auld
Assistant Executive Director

No specific R+R re fee splitting. Has not been before our Bd - however - if it were a complaint it would probably be placed in category of "unprofessional conduct"

AN EQUAL OPPORTUNITY EMPLOYER

AMERICAN
MEDCENTERS

July 29, 1986

Mr. Richard L. Auld
Assistant Executive Director
Minnesota Board of Medical Examiners
Suite 106
2700 University Avenue West
Minneapolis, MN 55114

Dear Mr. Auld:

It's not clear the intent of your inquiry regarding "fee splitting". In the broad sense, most multi-specialty group practices similar to the one in which I practice compensates physicians on the basis of a schedule that would provide some sharing component.

In our view, those health care systems or organizations that compensate physicians who freely participate, agree to the terms, and are treated equitably, meet the standards that your regulations should address. Those systems that use compensation mechanisms to create bias, cohersion or unfair leverage should be the focus of the regulations.

Sincerely,

Loren N. Vorlicky, M.D.
Vice Chairman & Medical Director

LNV1/vjt

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November 12, 1986

Mr. David Ziegenhagen
Minnesota Board of Medical Examiners
Suite 106
2700 University Avenue West
St. Paul, Minnesota 55114

Dear Mr. Ziegenhagen:

This letter is in response to the request of the Board of Medical Examiners for outside information or opinions to aid in its consideration of the adoption of new rules governing fee-splitting. Fredrikson & Byron represents many physicians and medical practices. We have frequently been asked to advise clients on transactions or arrangements that give rise to questions under the fee-splitting provision of the Medical Practice Act.

The prohibition against fee-splitting was recently amended. The new provision is arguably broader than its predecessor. The following conduct is specifically prohibited and is deemed grounds for disciplinary action against a physician: "Splitting fees, or promising to pay a portion of a fee or a commission, or accepting a rebate." Minn. Stat. § 147.021, subd. 1(p).

The health care industry has undergone dramatic changes in recent years. More than ever before, the practice of medicine must be conducted as a business. As physicians respond to economic pressure, business arrangements that were unheard of ten, or even five, years ago are now commonplace.

We present you with a number of hypothetical situations. These are the types of cases that often give rise to questions under the fee-splitting prohibition. While we have drawn from our experiences over many years with many different clients, we do not wish to imply that our clients have employed all or any of these types of arrangements. We offer them only for illustration purposes in order to assist in your development of appropriate fee-splitting rules.

1. A group practice (partnership, professional corporation, or business trust) compensates its physicians, including non-owners, by splitting patient revenues in accordance with a predetermined formula, which may include a split of revenue between an "attending" physician and a "consulting" physician. Physicians may also be compensated for generating referrals.

2. A physician or group practice enters into a joint venture or partnership with another physician or group practice, or with a nonprofit hospital. The partnership or joint venture provides medical services, possibly coupled with technical services (e.g., in an imaging facility), to patients. Patient revenues are split among the participants without regard to who performed the service.

3. A group practice composed of primary care physicians contracts with a specialist or group of specialists to provide services to the patients of the primary care group. The specialists see and treat patients at the primary care physicians' facility. The primary care group provides necessary non-physician personnel, all necessary supplies, and bills patients and third-party payors for the services of the specialists. The primary care group retains 40% of the gross patient care revenues for work performed by the specialists. The remainder is passed on to the specialists.

4. The same facts as Example No. 3, except that the primary care group retains a percentage of the net patient care revenues for work performed by the specialists. The remainder is passed on to the specialists.

5. The same facts as Example No. 3, except that the primary care group can demonstrate, and in fact recites in its agreement with the specialists, that historically its overhead has equalled 40% of its gross revenues. The primary care group's overhead includes facility costs, non-physician personnel, supplies, administrative services, billing and collection, etc.

6. The same facts as Example No. 5, except that the arrangement with the specialty group also includes procedures that are done at the hospital and that involve patients of the primary care group.

7. A primary care group enters into an arrangement with a group of specialists where the specialists are paid a fixed, predetermined monthly fee. As in previous examples, the specialists provide services on site at the primary care clinic. The parties agree to a budget, including projections of the volume of services to be provided by the specialty care group. On a periodic basis (e.g., quarterly, semi-annually, or annually), the parties compare the specialists' actual production with the projected or budgeted production. If actual production is less than budgeted, the monthly fee for the next period is decreased proportionately. Similarly, if actual production exceeds budgeted production, then the fee for the next period is increased proportionately.

8. The same facts as Example No. 7, except that the arrangement includes procedures that are performed at the hospital and that involve patients of the primary care group.

9. A clinic management company (either independent or related to the physician group) contracts to manage a physician group. The management company's fee is based on a percentage of gross patient revenues.

10. The same facts as Example No. 9, except that the management fee is based on a percentage of net patient revenues.

11. A physician or group practice has an independent contractor agreement with an organization (e.g., general partnership, limited partnership, or business corporation) that provides technical health care services (e.g., a laboratory, an imaging facility, a lithotripter, etc.). The physician or group practice provides professional medical services to patients who are treated at the organization's technical facility. (The physician or physicians may or may not be investors in the organization.) Some patients or third-party payors may be billed a "global charge" including both professional and technical components. Other patients or third-party payors may be billed separately for the professional and technical components of the service. In both cases, the ratio betwee the professional and technical components remains constant, yet the dollar amounts may vary, depending on the charge that is assessed to the patient or that has been negotiated with a third-party payor. For example, the

parties may agree that the professional component will at all times equal 33% of the total charge and that the technical component will comprise the remaining 67%. If a discount is given, the ratio between the two components of the charge remains constant, and adjustments, if required, are made between the parties.

We appreciate the opportunity for input in the rulemaking process. If you have any questions about our hypotheticals, we would enjoy an opportunity to discuss them with you. By copy of this letter, we extend the same invitation to Jack Breviu, who has encouraged us to submit this information to you.

Very truly yours,

FREDRIKSON & BYRON, P.A.

Konrad J. Friedemann

KJF/sjf
cc: Jack Breviu

minnesota chapter
american physical therapy association
2353 rice street north, st. paul, minnesota 55113

July 30, 1986

Mr. Richard L. Auld
Assistant Executive Director
Minnesota Board of Medical Examiners
Suite 106
2700 University Avenue W
St. Paul, MN 55114-1080

Dear Mr. Auld:

We are writing in response to your recent request for input regarding fee-splitting. The Code of Ethics of the American Physical Therapy Association (APTA) prohibits fee-splitting among physical therapists or with any referring practitioner.

The APTA and the Minnesota Chapter - APTA, have both issued position papers on referral-for-profit situations. These position papers are available upon request. Physical therapists are necessarily dependent (due to statute and third-party payor regulations) on physicians for referral for physical therapy services. This linkage can easily lead to exploitation of both the patient and the physical therapist. The primary issues are that it provides an incentive for therapy overutilization, and it acts as a barrier to open access of therapy providers.

Since the referring practitioner is held in a position of trust by the patients served, patients normally place unquestioning reliance on the physician's judgement. Patients are not usually in a position to identify overuse or misuse of the referred services.

When a physician can gain financially from the referral process, the potential for violation of the patient's trust is increased. The APTA further believes these practices harm the public, the medical profession, and the physical therapy profession.

Specific areas of potential problems include:

- Patients may be referred when services are not needed
- Patients may be referred for more services (type, quantity) than are needed
- Patients may not have available to them the physical therapy expertise best suited to their needs
- Patient's freedom of choice in selecting a physical therapist is limited.

Physical therapy (unlike x-rays and diagnostic tests) is an area of service which can be provided in excess of what is needed without potential harm to the patient. This factor makes it an attractive profit-making service and increases the potential for referral-for-profit situations.

The Department of Human Services has also shared concern in the issue of fee-splitting as it relates to overutilization of services paid by Medicaid.

The Minnesota Statute regulating the practice of physical therapy, also prohibits "dividing fees with, or paying or promising to pay a commission or part of his or her fee to, any person who contacts the physical therapist for consultation or sends patients to the physical therapist for treatment".

Because the Rules and Regulations pertaining to this portion of the Statute have not been promulgated by the State Board of Medical Examiners, it is unclear how this new statutory language will affect current practice.

The MN Chapter - APTA has tried to address what we consider to be unethical fee-splitting situations through the statute regulating the practice of physical therapy. We cannot directly affect statutes and regulatory procedures that guide the practice of medicine. We hope this information, however, will be helpful in your deliberations regarding fee-splitting.

Thank you for the opportunity to provide input on this critical issue in health care. The MN Chapter - APTA, will be glad to provide any additional comment or to work with you on this issue, if appropriate.

Sincerely,

Marlene Deschler, D.P.A., PT

Marlene Deschler, D.P.A., PT
President
MN Chapter - APTA

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MINNESOTA MEDICAL ASSOCIATION
612/378-1875

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October 13, 1986

Richard L. Auld
Assistant Executive Director
Minnesota State Board of
Medical Examiners
Suite 106
2700 University Avenue West
St. Paul, MN 55114-1080

Dear Mr. Auld:

The Minnesota Medical Association is responding to the Board's request for comments in developing an administrative rule on fee splitting. On June 14, 1986 the MMA presented this issue to the AMA Council on Ethical and Judicial Affairs. Additionally we solicited information from Minnesota physicians regarding arrangements currently used in practice.

The AMA informs us that a monograph on fee issues will be issued prior to the Interim 1986 Meeting in December. A copy of the document will be forwarded to you for consideration. Pending the release of that document we were directed to review the Current Opinions of the Judicial Council 3.04, 3.05, 6.02, 6.03, 6.10 and 8.05. Copies of these are enclosed. The discussion by the Judicial Council focused on two points.

1. The patients well-being must be the foremost consideration and the potential for both under- and over-utilization considered.

2. A patient should retain the right to alternatives and any system that channels or locks a patient in to a specific source or system should be explained and the options and implications offered or explained.

The MMA also submits for your consideration the enclosed description of current contractual relations. The MMA takes no position as to the merit of any of these arrangements but simply has compiled and is reporting them for your information.

The MMA will follow the development of this rule and provide additional information and opinion as we obtain it. Since I will be leaving the MMA for a new job October 13th, please direct future correspondence to LuAnn Brenno, Legal Counsel.

Sincerely,

Kathleen A. Meyerle, Director
Division of Policy and Liaison

KAM:mal

Current Contractual Relationships Involving Referrals Between Clinics and Specialist Physicians

The following are examples of relationships that have developed between primary care clinics and specialist physicians. The reasons for these relationships are many but include the primary care clinics' desire to provide comprehensive medical services to their service area and to reinforce patient identity with the clinic as provider of care. The specialists have found that their referral sources are becoming more restricted and many specialists have the desire to enter into numerous relationships described below.

On both sides there are marketing as well as financial justifications for the relationships. Clearly, many of the relationships are in response to the increasing competitiveness between and among physicians.

1. Clinic contracts with specialists to see patients in clinic (most common relationship)

   - Clinic bills and collects specialist professional fee
   - Clinic or specialist may control fee structure
   - Clinic pays specialist a percentage of gross fees
   - Clinic retains 45-55% of gross fees to cover clinic overhead

2. Clinic contracts with specialist to see patients in hospital or other location

   - Clinic bills and collects fee directly from patient
   - Clinic or specialist control fee structure
   - Clinic pays specialist a percentage of gross fee minus either full overhead charges (45-55%) or billing cost (10-15% from net gross)

3. Clinic contracts with specialist for patients to be seen in specialist's office

   - Clinic bills and collects directly from patient
   - Clinic pays specialist collections minus a percentage (10-15%) to cover billing and administrative costs

4. Clinic contracts with specialist to see patients in clinic

   - Specialist bills patients directly
   - Specialist pays clinic a rental fee for use of the clinic
   - Rental fee is based on time with a fixed cost for use of the clinic or a fixed overhead plus variable use rate

5. Specialist contracts with clinic to see patients in the clinic

   - Specialist bills and collects from patient directly
   - Specialist pays clinic a percentage of his gross charges (25% in one case) to cover use of clinic facilities and materials

6. Clinic has contract with specialist for provision of specific procedure or test

   ° Patient is sent to specialist for procedure or test
   ° Specialist interprets results and bills clinic with discount based on volume of patients
   ° Clinic interprets report or results
   ° Clinic bills and collects from patient directly

7. Clinic contracts with specialist for provision of particular services

   ° Specialist discounts fees based on volume of patients with a starting discount (10%), which increases based on volume of referrals
   ° Patient is seen at clinic or in specialist's office
   ° Clinic bills and collects from patient directly

8. Clinic contracts with specialist for provision of services

   ° Clinic pays specialist a monthly salary reviewed and adjusted based on production
   ° Clinic bills and collects from patient directly

The following are modifications to the above examples:

   ° All arrangements may or may not be exclusive
   ° Medical records are maintained by the clinic, specialist or both
   ° Clinic may or may not list specialist as consultant on signs and letterhead, but most often do
   ° Overhead may or may not be specifically defined in contract
   ° Relationships may be specifically outlined in contract or less formal and verbal

TCE:crm

MINNESOTA PSYCHOLOGICAL ASSOCIATION
SUITE G-2
55 SHERBURNE AVENUE
SAINT PAUL, MINNESOTA 55103
(612) 293-1873

July 25, 1986

Mr. Richard L. Auld
Minnesota Board of Medical Examiners
Suite 106
2700 University Avenue West
St. Paul, Minnesota 55114-1080
ATTENTION: Fee Splitting Comments

Dear Mr. Auld:

Pursuant to your request for information, I have enclosed two documents relative to the issue of Psychologists and fee splitting.

Psychologists who are members of the Minnesota Psychological Association are bound by their Code of Ethics. Principle 6d of the ETHICAL PRINCIPLES OF PSYCHOLOGISTS deals with fees. Further, in order to retain their license, psychologists must adhere to the fee for services rules of the State Board of Psycholgy. (Reference 7 MCAR 10.008, H 3,4,5 & 6)
From our perspective, fee splitting is prohibited in both cases.

If you desire any additional information, please advise.

Sincerely,

William G. Strusinski
Executive Director

in the course of their work as psychologists. They reveal such information to others only with the consent of the person or the person's legal representative, except in those unusual circumstances in which not to do so would result in clear danger to the person or to others. Where appropriate, psychologists inform their clients of the legal limits of confidentiality.

a. Information obtained in clinical or consulting relationships, or evaluative data concerning children, students, employees, and others, is discussed only for professional purposes and only with persons clearly concerned with the case. Written and oral reports present only data germane to the purposes of the evaluation, and every effort is made to avoid undue invasion of privacy.

b. Psychologists who present personal information obtained during the course of professional work in writings, lectures, or other public forums either obtain adequate prior consent to do so or adequately disguise all identifying information.

c. Psychologists make provisions for maintaining confidentiality in the storage and disposal of records.

d. When working with minors or other persons who are unable to give voluntary, informed consent, psychologists take special care to protect these persons' best interests.

Principle 6
WELFARE OF THE CONSUMER

Psychologists respect the integrity and protect the welfare of the people and groups with whom they work. When conflicts of interest arise between clients and psychologists' employing institutions, psychologists clarify the nature and direction of their loyalties and responsibilities and keep all parties informed of their commitments. Psychologists fully inform consumers as to the purpose and nature of an evaluative, treatment, educational, or training procedure, and they freely acknowledge that clients, students, or participants in research have freedom of choice with regard to participation.

a. Psychologists are continually cognizant of their own needs and of their potentially influential position vis-à-vis persons such as clients, students, and subordinates. They avoid exploiting the trust and dependency of such persons. Psychologists make every effort to avoid dual relationships that could impair their professional judgment or increase the risk of exploitation. Examples of such dual relationships include, but are not limited to, research with and treatment of employees, students, supervisees, close friends, or relatives. Sexual intimacies with clients are unethical.

b. When a psychologist agrees to provide services to a client at the request of a third party, the psychologist assumes the responsibility of clarifying the nature of the relationships to all parties concerned.

c. Where the demands of an organization require psychologists to violate these Ethical Principles, psychologists clarify the nature of the conflict between the demands and these principles. They inform all parties of psychologists' ethical responsibilities and take appropriate action.

d. Psychologists make advance financial arrangements that safeguard the best interests of and are clearly understood by their clients. They neither give nor receive any remuneration for referring clients for professional services. They contribute a portion of their services to work for which they receive little or no financial return.

e. Psychologists terminate a clinical or consulting relationship when it is reasonably clear that the consumer is not benefiting from it. They offer to help the consumer locate alternative sources of assistance.

Principle 7
PROFESSIONAL RELATIONSHIPS

Psychologists act with due regard for the needs, special competencies, and obligations of their colleagues in psychology and other professions. They respect the prerogatives and obligations of the institutions or organizations with which these other colleagues are associated.

a. Psychologists understand the areas of competence of related professions. They make full use of all the professional, technical, and administrative resources that serve the best interests of consumers. The absence of formal relationships with other professional workers does not relieve psychologists of the responsibility of securing for their clients the best possible professional service, nor does it relieve them of the obligation to exercise foresight, diligence, and tact in obtaining the complementary or alternative assistance needed by clients.

b. Psychologists know and take into account the traditions and practices of other professional groups with whom they work and cooperate fully with such groups. If a person is receiving similar services from another professional, psychologists do not offer their own services directly to such a person. If a psychologist is contacted by a person who is already receiving similar services from another professional, the psychologist carefully considers that professional relationship and proceeds with caution and sensitivity to the therapeutic issues as well as the client's welfare. The psychologist discusses these issues with the client so as to minimize the risk of confusion and conflict.

c. Psychologists who employ or supervise other professionals or professionals in training accept the obligation to facilitate the further professional development of these individuals. They provide appropriate working conditions, timely evaluations, constructive consultation, and experience opportunities.

d. Psychologists do not exploit their professional relationships with clients, supervisees, students, employees, or research participants sexually or otherwise. Psychol-

2. A psychologist must not offer psychological tests for commercial publication to publishers who have presented tests in an unprofessional manner and who have distributed them to other than qualified professional users.

3. A report of the results of a test shall include relevant reservations or qualifications regarding validity or reliability which a psychologist may have because of the testing circumstances or any deficiencies of the test norms for the individual tested, and how the psychologist has applied those reservations and qualifications to the score of the individual.

4. A test result or interpretation regarding an individual is private information.

G. Public announcement of services.

1. Public statements shall not include false or misleading information. They may describe fees, professional qualifications and services provided, but they may not evaluate services as to their quality or uniqueness and may not contain testimonials by quotation or implication.

2. A psychologist may not misrepresent directly or by implication professional qualifications such as education, experience or areas of competence. A psychologist may not misrepresent directly or by implication affiliations, purposes and characteristics of institutions and organizations with which the psychologist is associated.

H. Fees and statements.

1. A psychologist shall, when asked by a client about the cost of professional services, disclose the cost of services provided.

2. A psychologist shall itemize fees for all services for which the client or a third party is billed and make the itemized statement available to the client. The statement shall identify at least the date on which the service was provided, the nature of the service, the name of the person providing the service, and the name of the person who is professionally responsible for the service.

3. A psychologist shall not directly or by implication misrepresent to the client or to a third party billed for services the nature of the services, the extent to which the psychologist has provided the services, or the person who is professionally responsible for the services provided.

4. A psychologist shall not claim a fee for services unless the psychologist is either the direct provider of the services or the person who is professionally responsible for the provision of the services and under whose direction the services were provided.

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7 MCAR S

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5. No commission, rebate, or other form of remuneration may be given or received by a psychologist for the referral of clients for psychological services.

6. Except as provided by law relating to business organizations, a psychologist may not divide fees with another professional without the informed consent of the client and unless the division is in direct proportion to the services performed and the responsibility assumed by each professional.

I. Practicing without a license. A psychologist shall not aid or abet an unlicensed person in engaging in the private practice of psychology. A psychologist who supervises a person preparing for the professional practice of psychology according to Minn. Stat. S 148.97, subd. 3, clause (2), is not in violation of this rule if the person is not engaging in the private practice of psychology.

J. Welfare of students and research subjects. A psychologist shall protect the welfare of psychology students and research subjects and shall accord the students and human research subjects the client rights listed in C. and E., except for C.4., C.6., E.4., E.6., and E.9.

K. Violation of law. A psychologist shall not violate any law in which the facts giving rise to the violation involve the provision of psychological services. In determining whether a violation involves the provision of psychological services the board shall consider:

1. the nature and seriousness of the violation the psychologist is alleged to have committed;

2. the relationship of the alleged violation to the purposes of regulating the practice of psychology; and

3. the relationship of the violation to the ability, capacity, fitness or integrity of the psychologist in rendering psychological services.

In any board proceeding alleging a violation of this rule the proof of a conviction of a crime shall constitute proof of the underlying factual elements necessarily underlying that conviction.

7 MCAR S 10.009 Waivers and variances.

A. Waivers; application. A licensee or applicant for licensure may apply to the board for a time-limited waiver of any rule except for any part of a rule which incorporates a statutory requirement. The waiver shall be granted if:

1. the rule in question does not address a problem of significance to the public in relation to the practice of the licensee or application of the applicant;

Minnesota Speech-Language-Hearing Association

August 1, 1986

Minnesota Board of Medical Examiners
Suite 106
2700 University Avenue West
St. Paul, Minnesota 55114-1080
ATTN: Fee Splitting Comments

Dear Mr. Auld:

This letter is written in response to your letter of July 16, 1986 requesting comments on the topic of fee splitting from the perspective of MSHA's involvement in the health care profession. Due to the requested deadline of August 1, we were unable to meet as a large group to discuss this topic; the following information was obtained through phone conversations with members of MSHA, Dr. Charles Speakes, the Chair of the American Speech-Language-Hearing Association's Ethical Practice Board and Ellen Sampson, Legislative Council for MSHA.

Based on our conversations with people, the following situations potentially exist.

SITUATION #1: A Speech Pathologist contacts an Audiologist and says: "In my professional practice I see a large number of clients. Many of these clients are in need of audiological services. I would like to make an arrangement with you whereby I will refer all of my clients who are in need of audiological services to you. It will be the client's choice whether he/she wants to obtain services at your facility, however I will still refer them to you. This will increase your clientelle. In return, I request that you give a reduced fee to my client."

We believe that this type of situation is not unethical. A quality service is being provided for the client at no additional cost to the client. Also, the Speech Pathologist who is making the referral has no monetary incentive to refer in quantity; the judgement of the Speech Pathologist in making a referral remains objective.

In the second situation, the same initial conditions exist, however the arrangement between the Speech Pathologist and Audiologist is different.

SITUATION #2: A Speech Pathologist contacts an Audiologist and says "In my professional practice I see a large number of clients. Many of these clients are in need of audiological services. I would like to make an arrangement with you whereby I will refer all of my clients who are in need of audiological services to you. It will be the client's choice whether he/she wants to obtain services at your facility, however I will still refer them to you, this will increase your clientelle. In return, I want to receive "X" percent of the billable charge for each client referred; you would keep the other precent."

We believe that this type of fee splitting situation is unethical being in violation of the Code of Ethics of the American Speech-Language-Hearing Association, Principle of Ethics IV "Individuals shall maintain objectivity in all matters concerning the welfare of persons served professionally."

By receiving a fee for each processed referral, the Speech Pathologist's objectivity in making the referral is impaired; objectivity is clouded by the monetary incentive.

SITUATION #3: A long term care facility (LTCF) wants to offer therapy services to its residents but does not want to hire therapists directly. Instead, the administrator of the long term care facility contacts a rehabilitation agency and contracts with the rehabilitation agency to provide therapy services on the LTCF's premises. A contractual arrangement is made between the rehabilitation agency and the LTCF.

It is our thinking at this time that a LTCF that contracts with an outside agency for therapy services should be able to charge a fee for rental of LTCF space, use of LTCF equipment as well as direct services rendered by the LTCF's support staff. The cost of these items should be based on actual expenses. The reimbursement mechanism for these items should be specified as a provision in the contractual arrangement between the LTCF and the agency.

The above remarks address different situations that were discussed in our telephone conversations. They are not intended to be inclusive in nature or limited to professions named.

If you have any questions or if we can be of further assistance to you in providing comments, please contact us at the above address or phone number.

Sincerely,

Jan K. Luker

Jan K. Luker, M.S.T., CCC-Sp
Co-Chair MSHA Third Party
Reimbursement Committee

Claudia D. Hawley

Claudia D. Hawley, M.A., CCC-A
Co-Chair MSHA Third Party
Reimbursement Committee

JKL/CDH/ss

cc: Ellen Sampson, Legislative Council for MSHA
Lois White

MSPhA
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July 31, 1986

Richard L. Auld
Assistant Executive Director
Minnesota Board of Medical Examiners
2700 University Avenue West Suite 106
St. Paul, Minnesota 55114-1080

Dear Mr. Auld:

This is in response to your letter of July 16 soliciting comment regarding the matter of fee splitting by physicians.

The Minnesota State Pharmaceutical Association is a professional association of nearly 2,000 individual pharmacists practicing in a variety of settings including community pharmacies, hospitals, nursing homes and educational settings. Approximately 1/3 of our members are pharmacy owners with the remainder employees or in other capacities.

MSPhA is cognizant of the dynamic changes in health care delivery and the economic structure of health care. We realize this state of flux brings pressures on traditional relationships between and among health care providers, patients, employers, subscribers, and others. Non-providers appear to be engaged in decisions which directly impact on patient care.

With regard to the matter of fee splitting, the Board of Medical Examiners should consider the issue of fee splitting not only between and among physicians but between physicians and other licensed health care providers such as dentists, pharmacists and others. As it is contrary to rules of the Board of Pharmacy for a pharmacist to accept a kick-back, so should it be for a physician to accept a kick-back, irrespective of the source. The additional matter of physician ownership of a pharmacy is a matter which has been addressed in some states, most notably California, and relates to another form of fee splitting - i.e. a means by which a physician receives income from another source without directly providing service.

The Minnesota State Pharmaceutical Association would be pleased to offer its assistance to the Board of Medical Examiners in addressing these issues and would look forward to seeing a working draft of the Board of Medical Examiners Rule in this subject area. Please keep us informed of progress in developing this rule and please call on us if we can be of assistance.

Sincerely,

Donald A. Dee

Donald A. Dee
Executive Director

DAD/mje

Minnesota Nurses Association
1821 UNIVERSITY AVENUE, SUITE N-377
ST. PAUL, MINNESOTA 55104
(612) 646-4807

July 31, 1986

Richard Auld
Assistant Executive Director
Minnesota Board of Medical Examiners
Executives Offices, Suite 106
2700 University Avenue West
St. Paul, Minnesota 55114-1080

Dear Mr. Auld:

I am writing in response to your letter of July 18th requesting information relevant to your promulgation of rules on fee splitting.

As you may be aware, the vast majority of Registered Nurses practice as employees, and do not receive reimbursement directly from either patients or third party payors. As a result, few nurses practice in a setting where fee splitting could become an issue.

A few hundred Minnesota RNs have "Advanced Practice" or "Expanded Role" practices and receive direct reimbursement. This group includes Nurse-Midwives, Nurse-Practitioners, Nurse Anesthetists and Clinical Nurse Specialists. Because of the delegated medical functicns performed as a part of these practices, a collegial relationship between the nurse and the physician is usually necessary. It is in this context that the issue of fee splitting could conceivably arise.

In an effort tc be responsive to your inquiry, I talked with both a Nurse Anesthetist and a Nurse Midwife from our membership who are knowledgeable regarding these two areas of practice. Neither was aware of fee splitting as an issue. In the seven years I have been with the MNA, I have never heard of an incident of fee splitting, nor have I heard the issue receive any discussion. From the information I have, the issue appears to be a "non-issue" within the nursing community and I can, therefore, contribute little to the discussion at this point.

I wanted to offer these additional resources:

Karen Hangsleben
Chair, Local Chapter IV-6
American College of Nurse Midwives
Fairview-St. Mary's OB/GYN
Suite 515
606 24th Avenue South
Minneapolis, Minnesota 55454

Phone: 339-1471

Marvin Lang, President
Minnesota Association of Nurse Anesthetists
2353 North Rice Street
St. Paul, Minnesota 55113

Phone: 483-1680

Please put me on your list to receive proposed rule drafts and notices. I commend you on your efforts, and remain willing to be of any assistance I can.

Sincerely,

Kathleen Cota

Kathleen Cota, RN, JD
Associate Executive Director,
Policy Analysis and Advocacy

Association Legal Counsel

cc: Karen Hangsleben
Marvin Lang

KC:hc

The National Board of Pediatric Nurse Practitioners & Associates

414 Hungerford Drive, Suite 310, Rockville, Maryland 20850 Telephone: (301) 340-8213

Executive Director
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Robert L. Lederer, M.D., F.A.A.P.
Marion H. Baker, R.N., C.P.N.P.
Brenda M. Cruikshank, M.D., F.A.A.P.

July 30, 1986

Richard L. Auld
Assistant Executive Director
Minnesota Board of Medical Examiners
Suite 106
2700 University Ave. West
St. Paul, MN 55114-1080

Dear Mr. Auld,

I have referred your letter requesting information on fee splitting to the PNP association-NAPNAP. As a membership organization, NAPNAP can best provide comments on this topic. The National Board is a credentialing agency and as such does not issue statement or opinion on delivery of health care services. I feel certain that NAPNAP can be more helpful to you in this area.

Sincerely yours,

Nancy A. Dickenson-Hazard

Nancy A. Dickenson-Hazard, RN, CPNP, MSN
Executive Director

NDH/bp

cc: NAPNAP National Office

STAFF COMMENTS

This section includes some comments on the state reports received. The majority of these states fit into one of two catagories. Thirteen have brief laws, like Minnesota's, and ten have no fee splitting laws or rules, at all.

Some states have enacted laws which includes fee splitting as grounds for suspension or revocation of a license to practice medicine. A sample of the wording commonly used in such cases is "division of fees or agreement to split or divide the fees received for professional services with any person for bringing or referring a patient." Some use the term "rebating". However, all states listed below are similar to Minnesota's current statute in that they (a). Include fee splitting under grounds for disciplinary action, (b). The wording is brief and similar to that above and (c). They have no rules that further define fee splitting:

Alabama
Delaware
District of Columbia
Iowa
Kansas
Maryland
Michigan
Nebraska
Nevada
Ohio
Rhode Island
South Dakota
Tennessee

The following states have no laws and no rules on the subject at all:

Alaska
Arizona
Connecticut
Hawaii
Kentucky
New Hampshire
North Dakota
Oregon
Vermont
Wyoming

The last group of states are twelve which have either more extensive laws or rules, or have unique properties worthy of special mention. Arizona is included again in this section (also shown previously in the catagory of no laws - no rules states), as well as Maryland (also shown in the brief law catagory).

Arizona - Although Arizona's law does not specifically refer to fee splitting, it does prohibit rebates. It also makes any violation of federal regulations an offense-and not just in relation to federal drug laws as is common in several other states. Therefore, since Medicare and Medicaid prohibits fee splitting, indirectly, so does Arizona law.

California - The language of California's statute is particularly specific and provides an excellent model for rules to further define fee splitting in Minnesota. It also prohibits a licensee from inappropriately referring patients to organizations in which the licensee has an interest. Further, the law prescribes a penalty for conviction, which includes imprisonment and/or a fine. However, the California Attorney General's Office has taken the position that hospital-based physicians may use fee-splitting with the hospital in appropriate and fair proportions.

Colorado - Colorado law explores, in connection with fee splitting, the role of an independent marketing agent or advertising agent. The statute allows a licensee to pay an agent for marketing services, based on results or performance, or on a per patient basis. The Board acknowledges it has no jurisdiction to regulate the ad agency, but reserves the right to apply for an injunction in district court if advertising is found by the court to be false or misleading. The law goes on to allow recovery by anyone who pays a fee illegally as defined therein. Colorado makes non-compliance a misdemeanor (class 2) for 1st offense, and a class 5 felony for second and subsequent offenses.

Illinois - This state attacks fee splitting by prohibiting the giving or accepting of rebates or fees for services not actually rendered. The law does not presume to deny partnerships or corporations the right to share in the profits of that venture, however, so as to eliminate any possibility for ambiguity, Illinois law then specifies that if 2 or more licensees concurrently render professional services, to a patient, they may legally divide a fee so long as the patient has full knowledge of the division and the division is "made in proportion to the services performed and responsibility assumed by each." Inclusion of such a provision in Minnesota rules would go far to eliminate the possibility of a "gray area" developing in a situation certain to elicit inquiry.

Indiana - This state's fee splitting rules approximate those of the state of Illinois. However, in addition, Indiana rules prohibit a licensee from charging excessive fees, and then sets forth the standards to be considered as the licensee establishes his/her fees for services provided. The standards include R & C charges in the locality, quality of performance, experience and reputation and how long he/she has seen the patient. This law allows a medical society or association to operate a patient referral program approved by their licensing Board.

Maryland - This state's Medical Society responded to our survey and provided us with a copy of the Society's own ethical opinion on fee splitting. The language of that opinion would be helpful if the Committee is considering addressing such issues as husband/wife physician teams.

Missouri - Missouri simply includes fee splitting under unethical and unprofessional conduct, with no further mention or explanation of the issue.

New Jersey - In addition to prohibiting receipt of fees for services not rendered, New Jersey's statute focuses more on kickbacks. Kickbacks in connection with the sale of a device or a drug receive specific attention. Disclosure to the recipient is required regarding the actual cost to the licensee for a device. A licensee cannot receive anything of value for prescribing or promoting any drug, nor can he/she sell free samples.

New York - This state's law allows the licensee to pay up to 33 1/3% of any fee received for X-Ray examination, diagnosis, or treatment to any hospital furnishing facilities for such examination, diagnosis or treatment. Again, professional medical corporations are not prohibited from sharing profits, except, in the case of care and treatment under workers compensation law. Medical and dental indemnity expense corporations may pro-rate allowances as long as, prior to payment, the licensee submits itemized statements for services rendered to the subscriber and the indemnity corporation.

Virginia - It is a misdemeanor in Virginia to violate their fee splitting law, which has language typical of that of other states already discussed. The issue is then reinforced by reference in the section defining unprofessional conduct in two ways: (1) By direct mention of the previously cited state law against the practice and (2) by making violation of federal law (i.e. Medicare/Medicaid) an actionable offense.

Washington - In Washington, the practice is not allowed of any licensee. No corporation in which the licensee has an interest may share a fee for a referral unless the referring practitioner makes full disclosure, in writing, to the patient of his interest in the firm. Violation is grounds for revocation or suspension. This state's law parallels that of New York in that it, too, allows the physician to pay 1/3 of the fee for x-ray examination, diagnosis or treatment to any hospital furnishing facilities or such examination, diagnosis or treatment.

Wisconsin - In prohibiting fee splitting, Wisconsin's law requires billing directly to the patient for services rendered (if a charge is generated), separate from any other physician or other person, corporation, institution, etc. (including a hospital). Like states previously mentioned, partnerships and corporations may pool and share profits. The law specifically speaks to and allows a hospital and its medical staff or a medical education research organization and its medical staff to contract with a physician to provide consultation services for attending physicians. But, the contracts must conform to certain requirements, such as establishing the physician's compensation. In this arrangement, the hospital is allowed to include a physician's charge on billings as long as it is so identified and the physician's name must be included. Violators may be fined up to $250 and may submit the Board's decision to judicial review.

Replies from Professional Organizations

Staff Comments

The concerns expressed by the organizations seem to be addressed by some portion of the laws and rules gathered in this packet.

For example, Fredrikson and Byron's hypothticals may be answered by considering language similar to that used in the states of New York and Wisconsin.

The presence of rules further defining fee-splitting will tend to alleviate the potential problems isolated by the APTA, if careful consideration is given to the laws of states like these: Illinois and Indiana.

The MMA looks to the Board to make sure the patient is protected from under-and over-utilization, and to make sure the patients are given alternatives and that full disclosure is required. See the laws of the state of Illinois.

Minnesota Psychological Association provides valuable input into their own existing guidelines.

Generally, the 9 replies received touched on concerns that should be of major interest to the Committee. Interestingly enough, these issues were addressed by other states in their rules or laws. This puts Minnesota in an advantageous position of drawing from the regulations of other states and tailoring its rules to the needs identified in this report and those identified by the Committee and the Board.

FEDERAL TRADE COMMISSION
WASHINGTON, D. C. 20580

BUREAU OF
CONSUMER PROTECTION

January 17, 1985

Leon Hickey, D.P.M.
New Hampshire Board of Registration in Podiatry
Health & Welfare Building
Hazen Drive
Concord, New Hampshire 03301

Dear Dr. Hickey:

Congress has charged the Federal Trade Commission ("Commission") with responsibility for enforcing the nation's consumer protection and antitrust laws.[1] The New Hampshire Board of Registration in Podiatry ("Board") has published notice of its intention to amend its rules and regulations. The Commission's Bureau of Consumer Protection appreciates the opportunity to express its views concerning the possible effects of these rules on consumers and competition.[2]

We support what we regard as the most important aspect of the proposed amendments -- the general broadening of permissible advertising by podiatrists. The Board formerly imposed broad restrictions on podiatric advertisements, including prohibiting the advertising of prices, new office openings and relocations, and claims of professional superiority. The elimination of these restrictions will increase substantially the amount and kinds of information that podiatrists are permitted to make available to consumers. Such information should enhance the ability of consumers to shop intelligently for podiatric services, and may lower the overall cost of such services.

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[1] Federal Trade Commission Act of 1914, 38 Stat. 714 (1914), 15 U.S.C. §§ 41 et seq. The Commission shares the responsibility for enforcing the antitrust laws with the Department of Justice.

[2] These comments represent the views of the Bureau of Consumer Protection of the Federal Trade Commission and do not necessarily represent the views of the Federal Trade Commission or any individual Commissioner.

Although the proposed rules represent a substantial step toward increasing consumer welfare and market efficiency, we wish to discuss several remaining proposals that could adversely affect consumers and competition among podiatrists in New Hampshire. The proposals we wish to discuss fall in two categories: (1) complete bans on certain practices, and (2) vague, subjective criteria governing podiatrists' conduct.

I. Complete Bans on Certain Practices

The Supreme Court has recognized that professional boards play an important role in formulating rules governing professional conduct. However, the Court also has noted that there are limits to the exercise of this authority. As the Supreme Court stated in striking down bans on competitive bidding among professional engineers, "[c]ertainly the problem of professional deception is a proper subject of an ethical canon. But . . . the equation of competition with deception . . . is simply too broad; we may assume that competition is not entirely conducive to ethical behavior, but that is not a reason cognizable under the Sherman Act, for doing away with competition." National Society of Professional Engineers v. United States, 435 U.S. 679, 696 (1978). See also FTC v. AMA, 94 F.T.C. 701, 1009 (1979) ("Ethical restraints can be justified under the rule of reason, therefore, only if they promote competition, rather than merely other social goals, and if they are not overly broad,"), aff'd, 638 F.2d 443 (2d Cir. 1980), aff'd mem. by an equally divided Court, 455 U.S. 676 (1982).

We would like to draw the Board's attention to the following three proposed rules that may be overly broad. First, Part Pod 501.06 would prohibit podiatrists from criticizing the services of other podiatrists or other health professionals. While the second sentence of this rule suggests that it would apply only to those situations in which the podiatrist lacks adequate information for such criticism, the language of the prohibition is much broader. On its face this rule would suppress the dissemination of truthful, useful information concerning the relative merits of the services offered by podiatrists. For example, the rule might well prohibit a podiatrist who is consulted for a second opinion from expressing an opinion different from that of the health professional initially consulted, and would certainly appear to bar any explicit critical reference to the first health professional's services. A podiatrist might also be prevented from acting as an expert in malpractice litigation, or even discussing with a patient the merits of a potential malpractice claim. Moreover, a podiatrist could be precluded from comparing the services he or she offers with those of a fellow health professional. This would apparently be the case regardless of the worth or veracity of the statements. While a rule prohibiting false or deceptive communications to patients would be appropriate, the rule as currently drafted impedes the dissemination of accurate

information that serves important societal goals, such as equitably resolving legal claims and limiting or correcting unnecessary or unwise medical treatment. We believe that a more narrow rule would protect against deception, and yet permit podiatrists to communicate important consumer information.

Second, Part Pod 404.01 would prohibit the seasonal practice of podiatry. We understand this rule to ban a podiatrist from practicing part of the year in New Hampshire. While we appreciate the Board's concern that podiatrists should provide full and competent care to the community, here again we believe that the Board's goal can be achieved in a less restrictive manner. The rule as drafted would seem to prevent podiatrists from structuring their practices in a manner that is responsive to public demand. It may well be, for example, that demand for the services of podiatrists is higher during certain periods of the year. Prohibiting seasonal practice may harm competition by creating an entry barrier to podiatrists willing to relocate on a part-time basis. The effect of such barriers is likely to be a shortage of podiatrists during certain periods of the year, and a concommitant increase in the price of podiatric services and/or waiting periods before patients are able to receive podiatric care during such periods.

Third, Part Pod 501.03 would ban the tendering or receipt of commissions by podiatrists for the referral of patients. Among other effects, the rule as drafted would appear to prohibit podiatrists from participating in referral services that operate on a commission basis. Such services may be valuable in helping consumers locate appropriate medical care and, by facilitating the gathering of information by consumers, may increase competition among health care professionals. In addition, the proposed rule may also prohibit commissions in other circumstances where they may be appropriate. We would therefore recommend that the Board reconsider its decision to adopt proposed Part Pod 501.03 as currently drafted.

In view of the concerns we have raised regarding Parts Pod 501.06, 404.01 and 501.03, we ask that the Board consider whether there are ways to achieve its legitimate objectives while imposing less severe restraints on competition.

II. Vague, Subjective Standards Governing Podiatric Conduct

We turn now to certain rules that are vague, or that apply subjective standards that may unintentionally chill activity that the Board does not intend to prohibit. The first such rule is Part Pod 501.10, which would limit podiatrists' participation in educational programs to such programs as are "in keeping with the dignity of the profession and the custom of the podiatric

profession of the community." The scope of this rule is unclear and could chill podiatrists from participating in informative programs to the detriment of consumers.

Finally, we wish to raise several questions concerning Parts Pod 501.08, 503.01 and 503.02. The meaning of these proposed rules is likewise unclear. In 501.08 the Board appears to adopt by reference the rules of any professional society to which New Hampshire podiatrists belong. We point out that by doing so, the Board may be responsible for any anticompetitive or anti-consumer rules adopted by these societies. We raise a similar concern with respect to proposed rules 503.01 and 503.02, which seem to suggest that the Board intends to share its authority to regulate professional ethics with local and national podiatric associations. Rule 503.02 also would require that podiatrists practice in accordance with the highest ethical standards of the community. While we support the need for podiatrists to practice in an ethical manner, the adoption of vague, subjective standards may needlessly restrict activity not intended to be regulated.

The modifications we suggest are intended to allow the public access to the widest possible range of truthful information. Increasing the amount of truthful information available to consumers about health care providers is likely to increase consumer choice and the availability of services, and lower the overall cost of health care. Our suggested modifications would stimulate fair and reasonable competition among health care providers and, therefore assist in stimulating the efficient delivery of health care services. We hope that these comments are helpful in evaluating the Board's proposed rules.

In concluding, we wish to thank the Board for extending the comment period to permit us to submit these remarks.

Sincerely,

Carol T. Crawford

Carol T. Crawford
Director
Bureau of Consumer Protection

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Minnesota Physician

Volume 2, No. 5 August 1988

The Independent Medical Business Newspaper

Setting Limits

Awaiting Minnesota's New Fee Splitting Rules



BY ANNE L. SCHLUETER, J.D.

"Fee-Splitting" is a phrase that often draws shadows across the faces of health care providers. In a game of *Password*, physicians' common responses to the words "fee splitting," would include "illegal" "unethical" and "trouble." What the phrase would not elicit is a clear picture of exactly what business relationships are permissible. New guidelines, mandated by the State Legislature, began to be implemented August 1, 1988 and physicians must stand up and take notice.

Because the consequences of a finding by the Board of Medical Examiners or a Court that a provider has impermissibly engaged in fee splitting are potentially severe and the statutory and administrative definitions of fee splitting are vague, the words all too frequently result in fear and confusion over what is, and what is not, prohibited fee splitting.

The 1988 Minnesota Legislature passed revisions to the Medical Practices Act which elaborate upon the definition of prohibited fee splitting and impose disclosure requirements upon physicians engaged in certain business practices. This article reviews the history, origins and status of the Minnesota fee splitting law, discusses new requirements placed on physicians, and calls for physicians to become actively involved in the Board of Medical Examiners' ongoing rulemaking process.

The New Law: History and Origins

Although the Minnesota fee splitting statute just went into effect on August 1, the concept of encouraging patient disclosure of a physician's financial interests, and the debate among medical professionals over contract or capitated fees and fee splitting among practitioners, is anything but new. Indeed, financial arrangements among physicians and patients or employers requiring the provision of medical care for a fixed annual amount date back to the early nineteenth century.[1]

The public focused its attention on the custom of surgical specialists paying a part of their fee to referring general practitioners as early as 1904, when the *Chicago Daily Tribune* sent city surgeons a fabricated letter offering to refer patients for 25 percent of the fee. The newspaper article disclosed the names of 18 surgeons who accepted the solicitation. While area physicians denounced the paper on the grounds that publicity would arouse public distrust of the entire profession, other professionals contended that doctors should simply place a fair value upon their services and demand payment.

Historically, both the profession and the government have actively regulated physicians' fees and business relationships to protect patients and foster public confidence. In 1912, the American Medical Association adopted a revised code of ethics which affirmed the Association's power to discipline its members and condemned fee splitting agreements which amounted to bribes or kickbacks.

Governmental scrutiny of such practices stanied with the commencement of public funding for health care and the enactment of the Social Security, Medicare and Medicaid programs in the mid-sixties. Concern over corruption in these programs prompted Congress to pass federal Medicare and Medicaid anti-fraud and abuse laws prohibiting payments for referrals as well as other financial arrangements.

Until the 1970's, Minnesota physicians basically operated under two sets of rules. Because the federal anti-fraud and abuse laws only governed services funded by Medicare and Medicaid monies, payment agreements which were prohibited if they covered these patients were presumed to be acceptable for services paid for by the patient or other third parties.

In 1973, Minnesota enacted HMO laws which effectively put physicians at financial risk for health care decisions. Because of the structure of certain HMO models, discounting fees for services, undertaking medical care for capitated fees or at contract rates and, in effect, splitting fees among other HMO providers became the norm.

The alternative methods of health care delivery also spawned ethical debates because physicians who viewed themselves as patient advocates were thrust into the position of "gatekeepers." Referring a patient to a specialist or admitting a patient to a hospital potentially resulted in diminution of the physicians income. Like the 1904 Chicago physicians, modern doctors making treatment decisions faced personal financial consequences, only this time it was the result of an institutionalized delivery system rather than a secret agreement voluntarily sought by general practitioners and specialists.

With no less than three systems (HMO, Medicare-Medicaid, and private payers) and accompanying conduct standards, it is little wonder that physicians are confused about which referral patterns and compensation formulas are permissible and which are prohibited.

Conflicting societal directives have compounded provider uncertainty over what business arrangements are allowed. Most physicians traditionally approach the delivery of health care based on first, the medical needs of the patient and second, the availability of medical technology to meet those needs, regardless of cost.

With society's blessing, the medical mission was to cure the sick, period. As the cost of care increased almost geometrically, (and the funds available to pay for care diminished proportionately), the message changed, reflected in part by new descriptions attached to health care. The terms "the medical profession," "hospitals," "physicians," and "patients" gave way to words like "the health care industry," "facilities," "providers," and "consumers," (all of which are the focus of "managed care").

The popularity of HMO's, PPO's and a host of other alternative delivery systems demonstrates that efficiency and cost containment are becoming more and more the hub of medicine. In short, one societal expectation mandates providers to conduct their affairs more like a business and less like a profession.

Concomitantly, those in charge of regu-

Continued on page 12

Fee Splitting

Continued from cover

lating providers maintain that because physicians are professionals, the primary goal of health care must be to cure the sick. Providers are told not to engage in activities that too closely resemble "business" (and therefore not suited to the medical profession). In today's competitive health care market, physicians are facing a conundrum: they are expected to provide quality patient care and develop cost-efficient methods of delivering care within the bounds of legal and ethical standards.

The 1988 Minnesota fee splitting bill statutorily addresses the scope of those boundaries. It was first read in the legislature on February 2, 1988, and became law on March 22, 1988 with very little floor discussion. The statute went into effect on August 1.

The law was appropriately referred to in the legislative session as "the Board of Medical Examiners bill." Most of the investigation and deliberation took place at the Board level, and was initiated long before the matter was presented to the legislature for action.

On May 21, 1986, the Board of Medical Examiners launched a Fee Splitting Study with a letter to the other 49 states, the District of Columbia and territories with medical review boards requesting that each state provide the Minnesota Board with copies of any statutes, rules or policy statements on fee splitting. Sixty-seven jurisdictions were contacted and 33 replied. The Minnesota Board staff then analyzed and summarized each state's rules, and commented to the Board.

Eleven states[1] had laws similar to Minnesota's former statute[2], that included fee splitting as a grounds for disciplinary action and had no administrative rules providing further guidance on fee splitting. Ten states[3] had no laws or rules on the subject and 12 states[4] had more extensive statues and regulations, some of which served as models for the Minnesota law.

For example, Indiana law requires that a physician's fees be reasonable and provide compensation only for services actually rendered. Like Minnesota's new law, Indiana, Washington, California, and Arizona all require varying degrees of patient disclosure of a physician's financial interests in related organizations.

The New Fee Splitting Definition: An Overview

The 1988 amendments to the fee splitting provisions of the Minnesota Medical Practices Act exemplify one attempt to balance the tension between conflicting expectations placed upon the medical profession. Two philosophies underpin the new fee splitting definition. First, that the physician should honestly facilitate the patient's participation in health care decisions, enabling the patient to make informed choices regarding costs as well as providers of services, drugs and other devices. Second, the physician should exercise medical judgment based upon the patient's medical needs and not upon the doctor's financial interests.

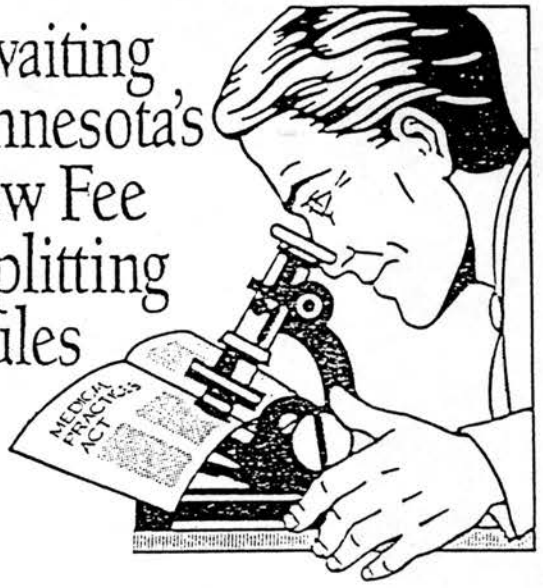
Disclosure of financial arrangements is therefore required and certain activities are prohibited. The statute does not prohibit all financial relationships among providers and thus, arguably, recognizes market pressures and providers' need to respond effectively in order to survive in addition to a doctor's right to make prudent economic investments when this activity does not encroach upon patients' rights or the tenets of medical ethics.

Although discussions with state legislators indicate the intent was not to change existing law as much as to clarify it, there are new requirements placed on physicians as a result of the amendments. Essentially the changes represent a form of health care consumer protection. Effective August 1, 1988, providers may be subjected to discipline by the Board of Medical Examiners for engaging in fee splitting, which now includes, without limitation:

1. Paying, receiving, or agreeing to receive, a commission, rebate, or remuneration, directly or indirectly, primarily for the referral of patients or the prescription of drugs or devices;
2. Dividing fees with another physician or a professional corporation, unless the division is in proportion to the services provided and the responsibility assumed by each professional and the physician has disclosed the terms of the division;
3. Referring a patient to health care providers (which includes chiropractors, dentists, osteopaths, pharmacists, physicians, podiatrists, surgeons and nursing homes) in which the referring physician has a significant financial interest unless the physician has disclosed the physician's own financial interest; and
4. Dispensing for profit any drug or device, unless the physician has disclosed the physician's own profit interest.

The physician must make the disclosures required in this statute in advance and in writing to the patient and must include in the disclosure a statement that the patient is free to choose a different health care provider.

However, the statute specifically does not apply to the distribution of revenues from a partnership, group practice, nonprofit corporation or professional corporation to its partners, shareholders, members or employees if the revenues consist only of fees for services performed by the physician or under a physician's direct supervision. By its terms, the statute also does not apply to the division or distribution of prepaid or capitated health care premiums or fee-for-service withhold amounts paid under contracts established under other state law.



Awaiting Minnesota's New Fee Splitting Rules

Fee Splitting Provisions: Specifics

1. Payments for Referrals:

The standard in the new law is almost identical to the payment for referral prohibition contained in the federal Medicaid and Medicare fraud and abuse statute. The effect of this section is that financial arrangements and contracts which may have been permissible if they specifically excluded Medicare and Medicaid patients, with certain exceptions, will now be prohibited in Minnesota for all patients, regardless of the payment source.

Because of the similarities between the new Minnesota law and the federal statute, physicians can probably obtain guidance from principles developed under the federal Medicare and Medicaid laws in analyzing whether their current financial arrangements require modification. Defining when payments are impermissibly made for referrals rather than for services rendered has resulted in controversy under the federal Medicare and Medicaid laws and will probably be the subject of questions for Minnesota physicians.

One of the more renowned cases under the federal law was *United States v. Greber*, 760 F.2d 68 (3rd Cir. 1985). In *Greber*, the court indicated that even if only a portion of physician payments were made to induce referrals (and a majority of the compensation was reimbursement for services actually rendered), the arrangement violated the prohibition against payment for referrals.

Minnesota law arguably rejects the *Greber* standard by including the phrase "primarily for referrals" in its statute. This phrase implies that a tangential desire to induce referrals will not, by itself, result in physician discipline. However, what threshold will be implemented for determining when payments are "primarily" for referrals remains unclear. This is one of the issues that the Board of Medical Examiners will address through rulemaking.

Unlike certain other questions generated by the new statute however, defining a threshold for the term "primarily" is not one easily suited by an administrative regulation.

The Health Care Financing Administration stated that the intent of the payment for referrals prohibition is not to penalize individuals participating in legitimate business transactions. Rather, it is to penalize those who engage in unethical and illegal financial arrangements such as kickbacks, rebates or bribes that unnecessarily increase the cost of health care programs.

Therefore, providers must insure that business arrangements and joint ventures serve valid business purposes, and that all related documents or discussions clearly establish this intent. Legitimate business purposes probably include expanding or protecting service areas (so long as it does not result in a monopoly or price fixing), increasing or upgrading equipment, reducing costs, improving quality of care, increasing efficiency in management and creating new investment opportunities.

Physicians should consider that while

Board Seeking Comment on Proposed Fee Splitting Rules

The Board of Medical Examiners is currently formulating specific rules implementing the new fee splitting laws and encourages comments on the following questions:

1. What should be the threshold level for defining the term "primarily for the referral of patients"?
2. How should the term "devices be defined in the rule? Is it equipment? Is it Ace Bandages?
3. What type(s) of written disclosures should be required by the rules? Will a sign in the office or notice on a prescription pad suffice? Are affiliated providers included in the disclosure requirement?
4. Should contract disclosure be required by the rules? (Such as disclosure of "terms of division," "physician's own financial interest," or physician's own "profit interest"?
5. What should be the percentage threshold for disclosing a "significant financial interest"?
6. Should certain types of investments or financial programs be considered automatic grounds for disciplinary action?
7. How should the term "dispensing for profit" be defined in the rules?

following protective procedures can not guarantee that their financial arrangements will withstand Board scrutiny, it can help minimize risks of severe sanctions. Generally, factors to be examined in structuring valid business relationships are:

1. Whether the relationship or commercial venture has a valid business purpose;

2. Whether the risk of success or failure is shared and the venture is properly capitalized;

3. Whether there is an impermissible link between ownership and referrals;

4. Whether termination provisions impermissibly penalize those who do not make sufficient referrals;

5. Whether payments are reasonable and issued for necessary services or items actually provided or whether they are impermissibly intended to compensate referral sources, and

6. Whether the relationship is disclosed to patients.

The Board of Medical Examiners is currently accepting comments from providers and will conduct rulemaking which may make requirements more specific. The outcome of the rulemaking process is uncertain. In the meantime, however, if the provider fully addresses the above considerations, he or she should be able to reduce the risk of unfavorable treatment by an enforcement agency and fulfill business and financial goals within the bounds of legal and ethical standards.

II. Dividing Fees With Another Physician or Professional Corporation:

There are three important points under this section. First, the statute is not a ban on dividing fees with another physician or a professional corporation. Rather, the law requires that if a physician divides fees, the division must be in proportion to the services provided and the responsibility assumed by each professional. Payments for physician services (e.g., consulting or emergency room coverage), management, administrative, billing and collection, marketing, quality assurance, peer review, utilization control and other services are permissible so long as the arrangement is properly disclosed and the fee provided is not unreasonable given the responsibility assumed by the payee.

Conversely, serious questions would be raised if payments (especially to referral sources) were either unreasonable or not based upon necessary services actually provided. For example, the services performed should be appropriate to the individual providing them (i.e., a doctor cannot be paid physician wages for providing grounds upkeep, or secretarial services), and the assistance contracted for must be necessary and benefit the payor (i.e., a physician cannot pay three different professional corporations for performing billing and collection services when that function is already provided). Providers should also be careful to maintain adequate documentation covering the fact that services were rendered, and the amount paid for those functions.

Second, the statute specifically does not apply to the distribution of revenues from a partnership, group practice, nonprofit corporation, or professional corporation to its own partners, shareholders, members, or employees if the revenues consist only of fees for services performed by the physician or under a physician's direct supervision. By its terms, the statute also does not apply to the division or distribution of prepaid or capitated health care premiums or fee-for-service withhold amounts paid under contracts established under other state law (i.e., HMO's).

Many group practices, partnerships and corporations compensate participants on the basis of ownership interests or production formulas. Amounts attributed to each physician production formula often include monies received by the practice as the result of services performed "in-house" by physician assistants or technicians who work under the doctor's supervision. These customs are not affected by the new law.

Instead, the "evil" to be prevented by this section probably is an apparent ownership interest that in fact is merely a facade to shield a partner who is the source of referrals or kickbacks and who receives payments that are unrelated to any capital investment or productivity factor. Likewise, the purpose for requiring payments to be based on each provider's contributions could be to prevent providers from using fee splitting conditions in a coercive manner against their colleagues.

In *Hauptman v. Grand Manor Health-Related Fac.*, 502 N.Y.S.2d 1012 (1986), a New York Court held that an arrangement which required an independent psychiatrist to pay 20 percent of his fees to a medical corporation or be barred from practicing in a certain nursing home was prohibited by New York fee splitting laws. The court focused in part on the fact that the provision was not a sharing of fees among colleagues in a group practice, rather it was a coercive measure against the psychiatrist.

Third, this section requires that the physician disclose the terms of any division of fees covered by the law to patients. The form and method for disclosure is discussed later in this article.

III. Referring Patients to Health Care Providers In Which The Referring Physician Has A Significant Financial Interest:

Again, it is important to note that the statute does not apply to the distribution of revenues from the doctor's own partnership or corporation and that Minnesota does not prohibit doctors from owning or investing in other health care services or entities, or from referring patients to those facilities. However if such referrals are made to a provider (including chiropractors, dentists, osteopaths, pharmacists, physicians, podiatrists, surgeons, and nursing homes), in which the physician has a significant financial interest, the patient must be informed of the financial interest in writing before the referral is made.

Interestingly, several of the state laws reviewed by the Board of Medical Examiners in drafting the bill either preclude physician financial investment in such outside interests or prohibit referrals to those parties. In Michigan, for example, physicians may not own an interest in a laboratory and Pennsylvania proscribes physicians from referring Medicaid patients to any health care business in which the physician has an ownership interest. The Minnesota Board of Medical Examiners evidently reached a policy decision to forgo complete domination of the private financial investments of physicians in favor of requiring a free flow of information upon which the patient may make medical treatment and expense decisions.

The issue of what constitutes "significant" financial interests will probably be addressed by the Board of Medical Exa-

Continued on next page

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miners through rulemaking. Although it appears the Board is considering a standard which focuses on a provider's percentage of ownership, it is unclear from what vantage point the Board will consider the term "significant" or demarcate the percentages.

For example, it is uncertain whether the Board will examine the percentage of the physician's overall income which is derived from the related organization, whether it will review only the percentage of ownership in the related company, or whether the issue will be reviewed on a case-by-case basis.

While a percentage formula could prove an acceptable measure of "significant interests," it may produce incongruous results. Fifty percent or more ownership in a related organization is clearly significant to the other organization, yet may provide little or no financial return to the referring doctor. Less than 50 percent ownership may also be significant if it provides the referring physician voting power or control over the organization's activities. However, even a one percent interest or holding one share in a profitable drug or equipment company could provide substantial and significant financial returns to the physician.

If the purpose of the statute is to protect patients by putting them on notice that a physician may have more at stake in a referral than the patient's medical needs, it would seem the standard should be based upon an "either-or" criterion: disclosure is required if the physician owns a significant interest in the provider to whom the referral is being made, and if the interest held by the physician represents a significant amount of the physician's income, regardless of the percentage decided upon by the Board. Given that the statute does not prohibit these financial investments, and only requires disclosure, a safe or conservative approach for physicians would be to err on the side of disclosure in close situations, from both vantage points discussed.

IV. Dispensing For Profit Any Drug Or Device:

First, physicians should realize that this section does not preclude them from dispensing drugs and devices for profit, rather, it requires full, written patient disclosure before doing so and informing the patient they are free to choose a different health care provider.

One of the unanswered questions under this section is the definition of "drugs and devices." Another issue is determining when a practitioner is "dispensing for profit," and whether it includes only items that are directly dispensed by the physician or whether it also covers dispensing drugs and devices by an entity in which the physician has an ownership interest and thus will gain benefit by the referral. Take the example of an ophthalmologist who has an ownership interest in a contact lens/eyeglass business next door, are the contact lenses and eyeglasses considered "drugs or devices"? A conservative approach would be to treat them as such until notified otherwise by the Board of Medical Examiners, and disclose the interest.

The discussion of significant financial interests in the previous section of this article apply to determining whether a physician is dispensing drugs or devices "for profit." Given that the statute does not prohibit profit interests, and only requires disclosure, a safe or conservative approach for physicians would be to err on the side of disclosure in close situations, from both vantage points discussed.

What will constitute a "referral" is important to all of the clauses in the new statute. In Washington, for example, it may include the physical proximity or arrangement of offices, any direct, indirect, written or oral statement, sign, symbol or gesture which suggest or indicate the physician's preference or hope that the patient utilize the services or items offered by an entity in which the physician has an interest (*Dayv. Inland Empire Optical, Inc.*, 456 P.2d 1011, Wash. 1969). While the "referral" issue may produce questions for physicians, probably the crucial step is defining, understanding and implementing the disclosure requirements.

V. Required Disclosures:

Effective August 1, 1988, the following arrangements must be fully disclosed to patients in writing before making referrals or dispensing drugs or devices, and the disclosure must state that the patient is free to choose a different health care provider:

a. Terms of the division of fees with another physician or a professional corporation to whom a physician makes a referral;

b. A physician's financial interest in any provider to whom the physician refers a patient when the physician has a significant financial interest in that provider, and

c. A physician's profit interest when drugs or devices are dispensed for profit.

Methods for fulfilling the disclosure requirements are probably of the most immediate concern to providers. Failure to provide advance, written disclosure to patients could result in disciplinary action against the physician. The discipline that may be [illegible] reprimand [illegible] one's license [illegible]

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Fee Splitting

Continued from page 14

over time) of financial arrangements with each physician to whom he makes referrals. Such a requirement might also seem overly invasive of a provider's private financial information, or be viewed as unduly opening proprietary business data to competitors.

Probably the minimum step for physicians is to post conspicuous signs in a reception area. The notice should indicate that the doctor may refer patients to, for example, ABC Physical Therapy group, that the physician has a significant financial or profit interest in ABC Physical Therapy group, and that the patient is free to seek services from that group or choose a different health care provider. The notice could also state that if the patient has any questions, he should discuss questions directly with the physician. Other steps that could be taken along these lines are to include such a statement in a patient brochure that every patient receives, or on a prescription pad or referral form.

Perhaps the middle road (but aimed at minimizing risk) is to develop a form notice that specifies what other physicians, professional corporations, and other providers of medical services, drugs, or devices in which the doctor has either significant financial interests or profit interests, as well as the general terms of any division of fees with other physicians and professional corporations. The form notice could also indicate why the doctor has these relationships (for example, because the doctor has worked with that particular group before and trusts their judgment), and direct the patient to his or her doctor with any questions. The notice should clearly, in bold type and capital letters, tell the patient that they are free to choose another health care provider. Procedurally, the physician could implement a system under which either the doctor or a nurse provides the patient with the notice at the time of referral or prescription.

Board of Medical Examiners Rulemaking Activities

Because of the many questions and concerns the new law raises, the Board of Medical Examiners recognizes the need to issue a common set of guidelines or rules for physicians. To that end, the Board has held hearings in various locations in the state. The Board is currently soliciting comments from providers and other interested persons to aid in formulating rules. It seems clear that rules will be promulgated, and that the process will take a minimum of several months to a year. Although some would argue that participation in this process is part of one's civic responsibility, at the very least, participation is in providers' best interest. The Board will accept both written and oral comments.

Once proposed rules are formulated, the Board will conduct another public comment period and input will be received and reviewed before adoption of final rules. In order to insure that the interests of all those likely to be affected by fee splitting rules are represented in the rulemaking process, the Board encourages participation at every stage of rule development.

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long enjoyed the reputation of being national leaders in not only responding to, but initiating creative developments in the health care field. Developing and implementing standards governing fee splitting represents another test of that reputation. Obviously once the Board of Medical Examiners adopts final rules, they will be the standards all physicians must abide by and live with for an indefinite period. A great deal of work by providers, government, and representatives alike will be required to resolve the issues spawned by the new statute. The task of addressing providers' concerns yet accomplishing the consumer-oriented purposes of the law is just beginning.

Although the amendments to the fee splitting provisions of the Medical Practices Act were aimed at clarifying prohibited practices and initiating disclosure obligations, the administrative rules formulated will in all likelihood contain the real "teeth" in the new requirements. Physicians would be well advised to first, conduct a type of "fee splitting audit" of their contacts and financial business arrangements. Second, until definitive rules are promulgated by the Board of Medical Examiners, doctors should consider taking a middle-of-the-road, yet conservative, approach in examining their business arrangements and in determining both what information they will disclose to patients and the method for disclosure.

Anne L. Schluter is an attorney with the Minneapolis law firm of Opperman and Paquin and represents many physicians, clinics and hospitals throughout Minnesota. Martin B. Ho is a summer law clerk with Opperman & Paquin and a law student at the University of Minnesota School of Law. Mr. Ho served as researcher for the article.

Endnotes

1. For an excellent discussion of the historical bases for modern regulation of medical fees and financial relationships, see *A History of American Medical Ethics, 1847-1912*, by Donald E. Konold (The State Historical Society of Wisconsin for the Department of History, University of Wisconsin, 1962.

2. Alabama, Delaware, District of Columbia, Iowa, Kansas, Nebraska, Nevada, Ohio, Rhode Island, South Dakota and Tennessee.

3. Prior to the 1988 amendment, Minnesota's fee splitting law simply provided that grounds for disciplinary action included: "splitting fees, or promising to pay a portion of a fee or a commission, or accepting a rebate," without further explanation. However, the statute also provided discipline could be imposed for violating any other state or federal law relating to the practice of medicine, or in part regulates the practice of medicine. This would include the longstanding prohibition against receiving or paying remuneration of any kind for the referral of Medicare patients or other services for which Medicare funds will provide payment.

4. Alaska, Connecticut, Hawaii, Kentucky, Maryland (although Maryland's Medical Society does have an ethical opinion on the subject), New Hampshire, North Dakota, Oregon, Vermont, and Wyoming.

5. Arizona, California, Colorado, Illinois, Indiana, Michigan, Missouri, New Jersey, New York, Virginia, Washington, and Wisconsin. ■

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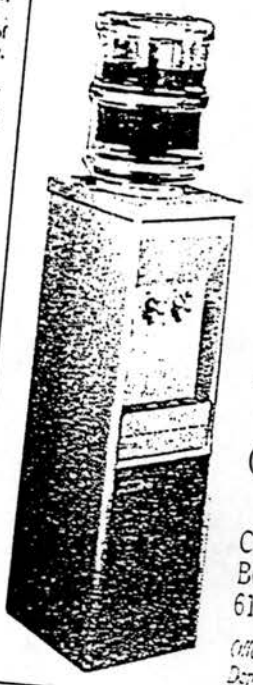

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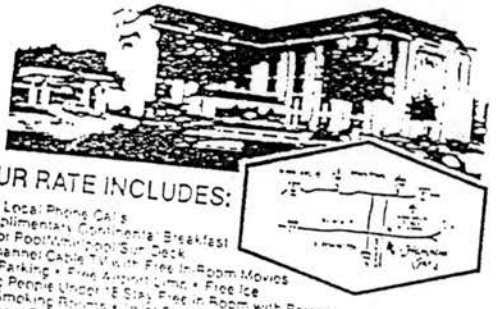

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may be drawn even tighter around referral practices once this study is submitted. For example, the Medicare Catastrophic Coverage Act, which called for this study, stated in part, "Because of the resulting economic alliance [arising from limited partnerships, etc.], physicians are less likely to exercise independent judgment in making referral recommendations. Moreover, such alliances pose a risk of inducing over-utilization even if the physician's income does not vary in proportion to the number of referrals made."

If that report doesn't lead to tighter controls, there is still the possibility of independent legislation achieving the same goal. For example, in 1988, Rep. Pete Stark, D-Calif., introduced HR 5198 (the Ethics in Patient Referrals Act), which, according to Strand, is a bill that would have virtually eliminated all physician investments, such as limited partnerships. Stark plans to push the bill forward in 1989.

Strand sees all of these developments as part of a disturbing trend that undermines the professional integrity of physicians and forces them to make choices that do not necessarily ensure the delivery of high-quality, cost-effective health care.

"I simply don't believe that a referral to an entity in which a physician has an ownership interest means the referral was unnecessary or is evidence of over-utilization," Strand says. "That assumes that physicians make their medical decisions based on reasons other than the best interest of their patients. I don't buy that assumption.

"The laws are becoming so restrictive, physicians may soon be forced to choose whether they're going to be involved in the health care profession as owners or as physicians.

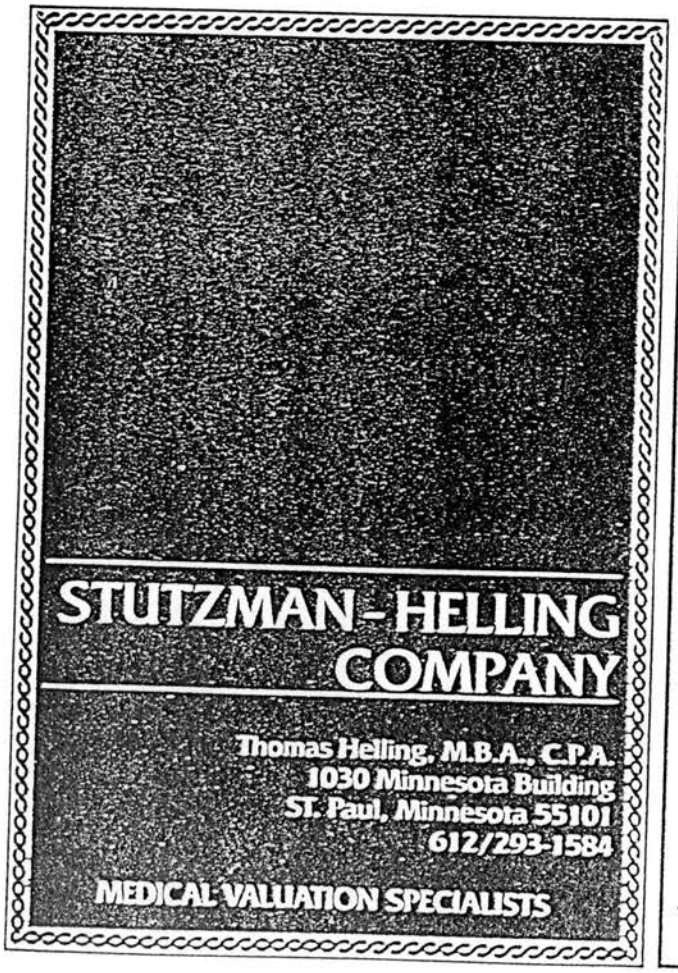
"Medicare is getting to be more and more expensive. And as costs continue to climb, the government is going to continue to look for ways to reduce utilization. They think enacting restrictions like these is the way to do that."

Strand obviously believes otherwise, and he encourages physicians to make their feelings known to Congress, either through letters or telephone calls.

"Sure, there have been some abuses of the Medicare system by some doctors," Strand says. "But because Congress can't figure out a way to identify those physicians or how they've managed to circumvent the fraud and abuse rules, they're going to restrict everybody."

This article was provided by the Minneapolis law office of Popham, Haik, Schnobrich & Kaufman, Ltd.

Chuck Benda is a free-lance writer living in Hampton, Minnesota.



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HHS Inspector General's 'Safe Harbors' May Be Stormier than You Think

Chuck Benda

On the surface, it would appear that nothing but smooth sailing will arise from the inspector general's proposed regulations supplementing the fraud and abuse anti-kickback provisions of the Social Security Act of 1972. After all, what could be less threatening than rules that simply set forth payment practices that do *not* violate the anti-kickback provisions of the Social Security Act?

The inspector general's report, published in the *Federal Register*, reads as if the people in the Department of Health and Human Services (HHS) are doing physicians a favor. If the response from physicians at the grassroots level is any indication, it may be that a majority of physicians concur. In 1987, when the inspector general published a notice of intent to develop these regulations, only 137 comments were received during the allotted response time. The American Medical Association has been, on the whole, supportive of the proposed rules, according to Steve Carter, chief executive officer of the Minnesota Medical Association. Unless some unforeseen storm blows in over the horizon, it looks as if the rules will be adopted within the next few months pretty much as they stand.

In spite of the seemingly benevolent nature of these proposed regulations, there are those who read the winds a bit differently. Among them is David Strand, a health care attorney and chair of the National Health Care Practice Group for the Minneapolis office of Popham, Haik, Schnobrich & Kaufman, Ltd.

"There has been a definite trend in recent years toward restricting all physician ownership of *any* entity to which they refer Medicare patients. These rules are the next step in that direction," says Strand, who has carefully monitored such regulations during his eight-year career in health care law. "If I were a physician, I'd be concerned about it."

The new rules supposedly make it easier for physicians to comply with the Medicare fraud and abuse laws by clarifying what has been a broad, unwieldy law. However, the real effect of these new rules, according to Strand, is that they may expose physicians to a greater risk of disciplinary action and place the burden of proof of compliance on the physician.

> "The real concern here is that we're rapidly approaching a time when doctors will not be able to ever refer Medicare patients to facilities where they have an ownership interest."

"You've got to view the proposed rules in light of past practice," Strand says. "With the broad interpretation of the laws in the past, enforcement was unlikely except in the most egregious situations. If the 'safe harbors' proposed by the inspector general go into effect, physicians will have to be more careful to comply with these rules in every business transaction, or they will be subject to civil or criminal prosecution. And if you're outside the safe harbor, you can be sure the transaction will be presumed to violate the rules. The real concern here is that we're rapidly approaching a time when doctors will not be able to ever refer Medicare patients to facilities where they have an ownership interest."

The original anti-kickback law dates back to the birth of the entire Medicare and Medicaid program, included in the Social Security Act of 1972. The fraud and abuse anti-kickback portion of that act provided for "criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce business reimbursed under the Medicare or state health care programs." Violators were guilty of a felony and could be fined up to $25,000 or imprisoned up to five years.

The all-encompassing scope of that law became clear in 1985 when the Third Circuit Court of Appeals ruled on payments between providers and referring physicians. In *United States v. Greber*, the court held that if even one purpose for such a payment was to induce future referrals, the physician would be in violation of the fraud and abuse anti-kickback provisions.

"That was such a broad view of the law that physicians and other health care providers suddenly wondered what activity they could possibly engage in without violating the law," says Strand. "There was no way a lawyer could give a physician a clear opinion on a proposed business arrangement. All

we could offer was our best guess."

The Medicare and Medicaid Patient and Program Protection Act of 1987 added two important new provisions to the fraud and abuse anti-kickback laws. First, the act established an intermediate penalty, short of criminal prosecution: If a physician or health care entity is found guilty of violating the statutes, the inspector general can prohibit the individual or entity from future participation in Medicare or Medicaid programs. Second, the act stipulated that the HHS inspector general would clarify the existing law by developing regulations and setting forth permissible activities.

"The laws are becoming so restrictive, physicians may soon be forced to choose whether they're going to be involved in the health care profession as owners or as physicians."

In 1988, the Medicare Catastrophic Coverage Act further restricted referrals in connection with home IV therapy. Under the act, physicians will not be allowed to refer Medicare patients needing IV therapy services to a health care entity in which the physician has any ownership interest whatsoever—other than stock in a publicly traded company.

Before that time, the Social Security Act prohibited physicians from referring patients to home health care entities in which the physician had more than a five-percent ownership interest.

It is on the heels of this series of regulations that the HHS inspector general proposes the rules establishing "safe harbors." Although these rules are too detailed to list here (a complete copy can be obtained by writing to the Office of Inspector General, Department of Health and Human Services, Room 5246, 330 Independence Avenue SW, Washington, DC 20201), generally, they provide narrow safe harbors in the following areas:

- investment interests,
- space rental,
- equipment rental,
- personal services and management contracts,
- sale of practice,
- referral services,
- warranties,
- discounts,
- employees,
- group purchasing organizations.

"The interesting thing about the investment interest rules is that in the original draft of the rules (published on December 23, 1989, but immediately withdrawn), there was an exception or 'safe harbor' for limited partnership interests," Strand says. "That safe harbor was omitted somewhere between the original draft and the newly published version."

Although Strand says the proposed rule changes are important and should be scrutinized by physicians who are dealing with Medicare dollars, it is the rule regarding investment interests that he thinks should be of particular concern. As it now stands, this segment of the rule provides a safe harbor only if the investment interest is in a corporation that has:

- total assets exceeding $5,000,000, and
- a class of equity security held by at least 500 persons.

"You may have a patient who legitimately needs a CT scan," says Strand, "and if you own $5,000 worth of that $1 million machine, you won't be able to refer a patient to that partnership without being at risk of civil or criminal prosecution. It's become clear that the inspector general is taking a very hard line.

"But there is a good side to these rules, too. Before, the law was so general that nearly everything you did was a potential violation. Now, there are some clear rules to follow. . . but if you don't follow them, the burden of proof is probably going to be yours. So you better be absolutely certain you're working within those safe harbors."

If and when the new rules go into effect, Strand recommends that any physician who refers Medicare or Medicaid patients ensure that all arrangements comply with the safe harbor stipulations.

"I know it sounds suspicious coming from a lawyer," Strand adds, laughing, "and I hate to say it, but if I were a physician considering a potential business arrangement that involved Medicare patients, I wouldn't enter into the arrangement without having a legal review."

According to the inspector general, a safe harbor *may* still be considered for a limited partnership. However, if such a provision is not included, the new rules will have a significant impact on the bottom line for many physicians, since it may effectively eliminate their ability to refer Medicare patients to limited partnerships in which they have any ownership.

While the health care community is busy pondering the proposed safe harbors, the inspector general is already off and running in another direction that very well may further restrict physician investment opportunities. A little-known clause in the same legislative act required the inspector general to conduct a study of physician referrals to entities in which they held an ownership interest and to deliver a report to Congress by May 1, 1989, calling for further regulation if necessary. The study will:

- Describe all physician ownership and compensation arrangements and the means by which they are marketed to physicians;
- Evaluate the potential of such arrangements to influence physician decision making and result in inappropriate utilization;
- Assess the practical difficulties involved in enforcement actions under current anti-kickback provisions; and
- Recommend possible changes in the law to strengthen protections against program abuse.

The inspector general's hard line

Minnesota Board of Medical Examiners

EXECUTIVE OFFICE
Suite 106
2700 University Avenue West
St. Paul, Minnesota 55114-1080
(612) 642-0538

July 20, 1988

To: The Record, Input on Fee Splitting

From: H. Leonard Boche
Executive Director HLB

Re: Comments Received from Members of the Executive and Legislative Committee of the Minnesota Academy of Family Physicians Meeting Tuesday, July 19, 1988 in Minnetonka

Persons present were: Lyle Munneke, M.D., Richard Streu, M.D., Robert Nesse, M.D., Timothy Pryor, M.D., Kirk W. Simpson, M.D., Scott M. Jensen, M.D., Chester Anderson, M.D., Donald S. Asp, M.D., Bruce Rorem, M.D., Linda Ferrario, M.D., John Carson, Roger Johnson and Virginia Barzan.

The issues which were brought to Leonard Boche, representing the Board of Medical Examiners, were regarding the 1988 amendments to the Medical Practices Act with special reference to the fee splitting provisions.

1) They inquired as to the nature of the problem which was presented to the Board of Medical Examiners which led to the new statutory fee-splitting language. They felt the new language was substantially a greater problem than what possibly it could have addressed.

2) They argued that the law was discriminatory in that the PPOs, HMOs, and large clinics, are exempt from the provisions on fee-splitting while the small primary care doctors are being singled out, bearing the brunt of the statutory provisions.

3) They argued that the language is unclear so that no one knows how to comply even if the physician wanted to.

4) Two members of the group argued that the rules should move away from legalisms and to an ethical standard to be interpreted by the Board.

5) They raised the question about the exempt organizations denying choice of vendor and withholding services, while the small provider must publish matters of financial interest.

6) The group by and large was hostile to lawyers and how they might interpret the law and/or rules which may be generated. One of the persons in the group volunteered that if he could be assured that there would be no lawyer public member on the Board of Medical Examiners, he would feel comfortable in having the Board interpret the statute directly, without rule writing.

7) Many members of the group saw non-compliance to the new fee-splitting language as a criminal act. Attempts were made to place the new language in the context of the Medical Practices Act and its enforcement by the Board of Medical Examiners. They were not sure whether they could trust the Board of Medical Examiners to make appropriate decisions on a case by case basis.

8) It was obvious that there was a high state of paranoia in the group. One person stated that doctors have been reassured in the past that new developments would be fine and in fact, those developments are not. The persons in the group were very suspicious of the intent and the implementation of the new statutory language.

HLB:blm

M E M O

DATE: August 25, 1988

TO: H. Leonard Boche
Executive Director

FROM: William R. Marczewski
Medical Regulations Analyst

PHONE: 642-0585

SUBJECT: FEE SPLITTING RULE FORUMS

In accordance with the "Notice of Intent to Solicit Information from Non-Agency Sources," the Minnesota Board of Medical Examiners conducted five forums throughout the State of Minnesota for the purpose of obtaining input on the proposed fee splitting rules. These forums were held in Mankato, MN (Mankato East High School) on July 13, 1988, in Duluth, MN (St. Mary's Hospital) on July 18, 1988, in Detroit Lakes, MN (Holiday Inn) on July 20, 1988, in Minneapolis, MN (Hennipen County Medical Center) on July 27, 1988, and St. Paul, MN (BME Board Room) on August 3, 1988.

Prior to taking comments and questions on the proposed rules, the Board members and staff explained the legislative history of the fee splitting law and the process for drafting rules in Minnesota.

The Mankato Forum had 17 people in attendance. The audience was composed primarily of physicians and clinic managers/officials. The comments, concerns and questions presented by the participants included:

1.) A request for clarification of the operative terms of the statute—"primarily for referral of patients," "significant financial interest," "profit interest," "dispensing for profit," "drugs and devices," and "disclosure."

2.) A concern was raised regarding how often "written disclosure" was to be repeated (each transaction, yearly, each billing sent?).

3.) Some participants expressed concern that senior citizens would be confused by the written disclosure notices and they might not take full advantage of the health care services available to them.

4.) One participant asked how the fee splitting law would affect volume discounts, package deals, and informal ways of soliciting business (i.e. Christmas card).

5.) Concern about how the fee splitting law may affect ancillary services within a clinic setting was also raised by a participant.

The Duluth Forum was attended by 14 participants. Physicians made up a majority of the audience. The comments, concerns, and questions presented at this Forum included:

1.) Repeated requests for clarification of the operative terms of the statute--"significant financial interest," "profit interest," "drugs or devices," and "disclosure."

2.) A number of participants requested that the physicians should not be overburdened with "disclosure" paperwork requirements.

3.) A participant requested clarification on how the fee splitting statute may effect "courtesy discounts."

4.) The question, Does the fee splitting law extend to physician "delegates" (i.e. physician assistants) working under a physician in a clinic setting? was raised by a participant.

5.) A comment was made that laboratory work and x-rays done in a group practice setting should be excluded from the fee splitting statute.

The Detroit Lakes Forum had nine people attending. It was composed mainly of physicians and clinic administrators. The comments, concerns, and questions raised at this Forum included:

1.) Repeated requests for clarification of the operative terms of the statute--"significant financial interest (Is it a percentage of direct ownership?)," "dispensing of drugs and devices (Does it allow for stocking and overhead charges?)," "dispensing for profit," and "terms of division."

2.) A number of questions were raised regarding whether disclosure of "financial interests" would be satisfied by posting a sign in a common area or by listing a notice in office handouts or ads.

3.) Some participants indicated a preference to keep the rules general.

4.) One participant stated a preference to go back to the legislature to change the fee splitting law rather than to write new rules. They recommended deleting sections two and four of the 1988 amendments.

The Minneapolis Forum had 32 participants composed primarily of physicians, lawyers, and health care representatives. Their comments, concerns, and questions included:

1.) Repeated requests for clarification of the operative terms of the statute. The wording needing clarification includes: "primarily for the referral of patients," "dispensing for profit," "profit interest," "significant financial interest," "terms of division," "division is in proportion to services provided," and "disclosure."

2.) Some participants recommended rewriting the statute rather than writing rules.

3.) Some participants noted agreement with the exclusion of prepaid health plans from the fee splitting law.

4.) A recommendation was made that the Board should look to the Federal Government's approach to fee splitting control.

5.) A participant recommended defining "overhead sharing" as a means of identifying what would be a "profit interest."

6.) Questions were raised regarding the statute's affect on group practices and volume discounts.

The St. Paul Forum held at the Board Meeting Room on August 3, 1988 had 16 participants. The audience was primarily composed of clinic administrators and managers. The participants raised the following concerns, comments and questions:

1.) What is the definition of "drugs and devices?"

2.) Would a blanket written disclosure satisfy the requirements of the disclosure provisions of the fee splitting statute?

3.) Will multiple owners of a joint venture be affected by the disclosure requirements of the fee splitting law.

4.) Will other agencies (State or Federal) be involved in monitoring fee splitting activities of the medical industry?

5.) To what extent do the disclosure requirements of the fee splitting statute apply to joint ventures?

6.) Do the disclosure requirements of the fee splitting law apply to contract consultants? Part-time employment relationships? Specialty arrangements?

7.) Would written disclosure at a corporate level satisfy the disclosure requirements of physicians under the fee splitting statute?

8.) Is profit sharing conducted by joint ventures within the disclosure requirements of the fee splitting statute?

SUMMARY OF FINDINGS

There were four recurrent concerns raised at each Forum. They were:

1.) A repeated request for clarification or definition of the operative terms within the fee splitting statute.

2.) An emphasis by forum participants to keep the rules simple and not unduly burdensome with paperwork. Or, in the alternative, to rewrite the statute in part.)

3.) A repeated request for clarification of the affect of the fee splitting law on joint ventures and other associated arrangements using volume discounts, package deals or courtesy discounts. Or, conversely, the effect of the fee splitting law on ancillary clinic service arrangements.

4.) An interest to keep health care consumers informed of choices without confusing or scaring them.

The overall response to the Forums by the medical community was to ask questions of the Board on the fee splitting law rather than to offer specific recommendations or comments. The number of follow-up calls or letters to the Board regarding the fee splitting rules number ? contacts. Of these contacts, only three offered recommendations concerning how the rules should be applied or possible wording for the rules. All other contacts to the Board were requests for background information on the fee splitting statute or requests to be placed on the Board's fee splitting rule mailing list.

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

BUREAU OF COMPETITION

December 7, 1988

William R. Marczewski
Medical Relations Analyst
Minnesota Board of Medical Examiners
Suite 106
2700 University Ave. W.
Saint Paul, MN 55114-1080

Dear Mr. Marczewski:

Pursuant to our conversation last week and in response to your letter to Elizabeth Gee, Assistant Director for Health Care in the Federal Trade Commission's Bureau of Competition, I am enclosing three sets of comments the Commission has filed in the past few years that touch upon the issue of fee-splitting.

You may also be interested in looking at some of the cases interpreting the Medicare and Medicaid Anti-Kickback statute such as United States v. Greber, 760 F.2d 68 (3d Cir. 1985) and the cases cited therein.

If you have any questions about the Commission's comments or about this issue generally, please call me. I can be reached at (202) 326-2747.

Sincerely,

Alan Soudakoff

Alan Soudakoff
Attorney

Bureau of Competition
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

COMMISSION APPROVED

OCT 17 1985

George M. Sanchez, O.D.
President
Arizona State Board of Optometry
1645 West Jefferson, Room 312
Phoenix, Arizona 85007

Dear Dr. Sanchez:

The Federal Trade Commission's Bureaus of Competition, Consumer Protection, and Economics[1] are pleased to submit comments concerning proposed rules of the Arizona State Board of Optometry ("the Board"). We begin by discussing the interest and experience of the Federal Trade Commission in examining the competitive effects of state regulation of licensed professionals. In Part II of this letter, we comment on the Board's proposed regulation R4-21-301.E, which would allow optometrists to work for a corporation or lay person. In Part III of this letter, we comment on proposed regulation R4-21-301.D.1, which would prohibit optometrists from splitting fees with a lay person or corporation. Also in Part III, we discuss proposed regulation R4-21-301.A, which would prohibit optometrists from paying for the solicitation or steering of patients. Finally, in Part IV of this letter, we comment on proposed regulations R4-21-301.B and R4-21-302.B, which would regulate certain types of advertising by optometrists.

I. Interest and Experience of the Federal Trade Commission

The Federal Trade Commission is empowered under 15 U.S.C. § 41 et seq. to prevent unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce. Pursuant to its statutory mandate, the Commission encourages competition among members of the licensed professions to the maximum extent compatible with other legitimate state and federal goals. For several years, the Commission has been investigating the competitive effects of restrictions on the kinds of business arrangements that state-licensed professionals, including optometrists, den-

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1 These comments represent the views of the Bureaus of Competition, Consumer Protection, and Economics of the Federal Trade Commission and do not necessarily represent the views of the Federal Trade Commission or any individual Commissioner. The Federal Trade Commission, however, has reviewed these comments and has voted to authorize their presentation.

tists, lawyers, physicians, and others are permitted to use in their respective practices. Our goal is to identify and seek the removal of those restrictions that impede competition, increase costs, and harm consumers without providing countervailing benefits.

II. Employment of Optometrists by a Corporation or Lay Person

Proposed regulation R4-21-301.E provides:

> This rule [which would, inter alia, prohibit optometrists from fee-splitting and from paying for the solicitation or steering of patients] shall not be interpreted to prevent the use of partnerships or professional corporations for the practice of optometry. Nor shall this section be interpreted to prohibit the employment of an optometrist by a corporation or lay person provided the exercise of the optometrist's professional responsibilities and discretion is not compromised.[2]

We believe that this regulation will likely increase competition in the market for optometric services in Arizona because it would allow the development of alternative forms of delivering optometric services, such as high-volume chain firms, that may be able to reduce costs through economies of scale. Such alternative forms of delivery can provide comparable quality services and put competitive pressure on traditional providers to pay greater attention to their own costs and fees.

The Federal Trade Commission's staff has issued two studies that provide evidence that restrictions on business relationships

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[2] This proposed regulation would be a change from Ariz. Admin. Comp. R. 4-21-02.A.2 (Aug. 31, 1977) which does not allow an optometrist to:

> Accept employment or the placing of himself under the control, directly or indirectly, of a Corporation, Trading Partnership or Layman, in which said optometrist performs optometric services for the public (employees excepted). Such acceptance shall be deemed to constitute "Unprofessional Conduct".

between optometrists and non-optometrists do not result in improved quality of care. In the first study,[3] conducted with the help of two colleges of optometry and the chief optometrist of the Veterans Administration, the price and quality of eye examinations and eyeglasses were compared across cities with a variety of legal environments. The data was collected by sending trained subjects to various cities to purchase routine eye examinations and eyeglasses. In the study, cities were classified as markets where advertising was present if there was advertising of eyeglasses or eye exams in the newspapers or the yellow pages. Cities were classified as markets with "chain" firms if eye examinations were available from large interstate optical firms.

The study found that prices charged in 1977 for eye examinations and eyeglasses were significantly higher in cities without chain firms and advertising than in cities with chain firms and advertising. The average price charged by optometrists in the cities without chain firms and advertising was 33.6 percent higher than in the cities with chain firms and advertising ($94.46 versus $70.72). Although not reported in the study, calculations of the data also show that prices were approximately 17.9 percent higher as a function of the absence of chain firms; the remaining price difference was attributed to the absence of advertising.

The data also showed that the quality of vision care was not lower in cities where chain firms and advertising were present. The thoroughness of eye examinations, the accuracy of eyeglass prescriptions, the accuracy and workmanship of eyeglasses, and the extent of unnecessary prescribing were, on average, the same in both types of cities.

The second study compared the cost and quality of cosmetic contact lens fitting by various types of eye care professionals.[4] This study was designed and conducted with the assistance of the major national professional associations representing ophthalmologists, optometrists and opticians. Its

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3 Bureau of Economics, Federal Trade Commission, Staff Report on Effects of Restrictions on Advertising and Commercial Practice in the Professions: The Case of Optometry (1980) [hereinafter cited as The Case of Optometry].

4 Bureaus of Consumer Protection & Economics, Federal Trade Commission, A Comparative Analysis of Cosmetic Contact Lens Fitting by Ophthalmologists, Optometrists, and Opticians (1983).

findings are based on examinations and interviews of more than 500 contact lens wearers in 18 urban areas. The study found that, on average, "commercial" optometrists -- that is, optometrists who were associated with chain optical firms, used trade names, or practiced in commercial locations -- fitted contact lenses at least as well as other fitters, but charged significantly lower prices.

These studies provide evidence that restrictions on employment, partnership, or other relationships between professionals and nonprofessionals tend to raise prices above the levels that would otherwise prevail, but do not seem to raise the quality of care in the vision care market.

Furthermore, in a case challenging ethical code provisions enforced by the American Medical Association ("AMA"), the Commission found that the AMA's rules prohibiting physicians from working on a salaried basis for a hospital or other lay institution and from entering into partnerships or similar relationships with nonphysicians unreasonably restrained competition and violated the antitrust laws.[5] The Commission concluded that the AMA's prohibitions kept physicians from adopting more economically efficient business formats and that, in particular, these restrictions precluded competition by organizations, such as health maintenance organizations, not directly and completely under the control of physicians. The Commission also found that there were no countervailing procompetitive justifications for these restrictions.

In conclusion, our experience in studying the effects of restrictions on the business practices of health professionals, particularly optometrists, leads us to believe that proposed regulation R4-21-301.E would increase competition in the market for optometric services in Arizona without causing harm to consumers. Consequently,[6] we urge the Board to adopt this regulation.

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5 American Med. Ass'n, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2d 443 (2d Cir. 1980), aff'd by an equally divided Court, 455 U.S. 676 (1982).

6 Arizona law prohibits optometrists from "knowingly having professional connection with or lending one's name to a person who is not a licensed optometrist." 1985 Ariz. Legis. Serv. 922, 924, 928 (West) (to be codified at Ariz. Rev. Stat. Ann. §§ 32-1701(9)(e), -1743(4)). A literal construc-

(Continued)

III. Fee-Splitting Regulations

We believe that the Board's proposed regulations that would prohibit optometrists from splitting fees with a lay person or corporation[7] and from paying for the solicitation or steering of patients[8] may unnecessarily restrict the development of innovative health care delivery systems such as preferred provider organizations ("PPOs") and health maintenance organizations ("HMOs"). PPOs and HMOs, however, can promote competition in the markets for delivering and financing health care services and provide benefits to patients and providers alike. The regulations may also restrict the development of referral services and franchise arrangements which can have a procompetitive effect as well. Consequently, we urge the Board to either modify these regulations so that only conduct that is truly harmful to the public is proscribed, or exempt from their application optometrists' basic contractual arrangements with PPOs, HMOs, other alternative health care delivery systems, referral services, and franchisors, which might technically be viewed as involving fee-splitting.

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tion of these statutes would not only prohibit optometrists from working for corporations or from participating in any vision care plan but would also prohibit optometrists from hiring opticians, receptionists, or any other employees who are not licensed optometrists. Such a construction might even prohibit optometrists from purchasing optometric supplies from a person who is not a licensed optometrist. Since we do not think that the Arizona legislature intended to proscribe such a wide range of business practices, we urge the Board to carefully construe the phrase "professional connection." A reasonable construction would only prohibit, as an improper "professional connection," an optometrist's association with an unlicensed person who engages in acts which either constitute "the practice of the profession of optometry," such as the "the examination or refraction of the human eye and its appendages," 1985 Ariz. Legis. Serv. 922, 924 (West) (to be codified at Ariz. Rev. Stat. Ann. § 32-1701(7)), or in acts which interfere with the optometrist's practice of the profession of optometry. Thus construed, these statutes do not interfere with the employment of optometrists by lay persons or corporations.

7 Proposed regulation R4-21-301.D.1.

8 Proposed regulation R4-21-301.A.

A. Impact on Alternative Health Care Delivery Systems

PPO programs are a relatively new type of plan for providing and paying for health care services while controlling health care costs. PPOs are an alternative to other health plans offered by employers to their employees such as Blue Cross/Blue Shield service benefit plans and HMOs. Although they exist in many different forms, all PPO programs involve a series of contractual arrangements between "preferred" health care providers and an intermediary or a third-party payer of health care benefits, such as an insurer or self-insured employer. PPOs often attempt to select preferred providers for their ability to deliver quality health care at a low cost. Enrollees in PPO programs are usually given financial incentives, typically waivers of copayments and deductibles, to use these cost-conscious preferred providers. PPO enrollees and third-party payers benefit from any reduction in health care costs achieved by a PPO program, while preferred providers benefit from increased patient referrals. PPO programs also allow preferred providers to retain their fee-for-service mode of practice. PPO programs can have a procompetitive effect by putting pressure on non-PPO providers to price their services competitively or to risk losing patients to the preferred providers. In addition, efficient PPO programs put pressure on competing health plans to control their health care costs or to risk losing enrollees to the PPOs.

Because PPOs can promote cost containment and stimulate competition in the health care industry, the Commission has viewed their development favorably. For example, in 1983, the Commission issued an advisory opinion to Health Care Management Associates ("HCMA")[9] concerning a PPO program in which HCMA proposed to serve as an intermediary between participating physicians and third-party payers. The Commission concluded that such a program would likely promote competition in the health care sector and would not violate the Federal Trade Commission Act or any other antitrust statute.[10]

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9 Health Care Management Associates, 101 F.T.C. 1014 (1983) (advisory opinion). See also Letter from Arthur N. Lerner, Assistant Director, Bureau of Competition, Federal Trade Commission, to Michael L. Denger, Counsel for Great-West Life Assurance Company and Health Data Institute (Sept. 24, 1985) (staff advisory opinion regarding proposed PPO).

10 See also Letter from James C. Miller III, Chairman of the Federal Trade Commission, to Representative Ron Wyden (July

(Continued)

HMOs are similar, in many respects, to PPO programs. Both types of arrangements utilize a limited panel of health care providers and afford coverage for a wide range of health care services. HMOs have built-in incentives to control health care costs and thus have a procompetitive effect in the market for health care services.[11] HMOs differ from PPOs in that they assume a responsibility to deliver these services directly to enrollees by employing or contracting with health care providers, as well as by undertaking the insurance function that third-party payers provide in PPO arrangements. In addition, HMOs generally provide coverage only if enrollees obtain their health care services from these participating providers. PPOs, by contrast, often provide coverage for use of nonparticipating providers, albeit at a higher out-of-pocket cost to enrollees.

The Board's proposed regulation that would prohibit optometrists from fee-splitting with a lay person or corporation may interfere with the operation of some forms of PPOs, HMOs, and other alternative health care delivery systems, as well as some referral services and franchise arrangements. For example, some PPOs require participating providers to remit to the PPO a percentage of the fees earned from treating PPO patients. Although not all PPOs are financed in this manner, this type of PPO may be attractive to many providers because the fees they pay to the PPO are directly proportional to the benefits (i.e., the number of referred patients) that they receive from participating in the program. Because the financial success of a new program often is uncertain, providers may prefer to participate in such PPO programs that "meter" benefits[12] rather than in programs that require substantial up-front capital contributions or annual charges. On its face, however, this type of PPO plan might

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29, 1983) (commenting favorably on proposed federal legislation which would have exempted PPOs from the coverage of certain state laws and regulations).

11 See, e.g., Bureau of Economics, Federal Trade Commission, Staff Report on the Health Maintenance Organization and Its Effects on Competition (1977).

12 A similar metering of benefits occurs where an optometrist pays a percentage of total net sales as rent. In State ex rel. Board of Optometry v. Sears, Roebuck & Co., 102 Ariz. 175, 427 P.2d 126, 128 (1967), the Arizona Supreme Court found such an arrangement "not only not illegal, but . . . a rather common mode of measuring the value of rental property."

violate proposed regulation R4-21-301.D.1, which provides, in part:

> An optometrist shall not: Divide, share, split, or allocate, either directly or indirectly, any fee for optometric services or materials with any lay person, firm or corporation.[13]

In addition, some HMOs, particularly those known as the IPA (individual practice association) type, hold back a certain percentage of each individual provider's fees for services rendered in order to create a reserve to pay for an unexpectedly high use of services by the entire subscriber population. This "holdback" fund is later distributed pro rata to the providers if the program's aggregate utilization levels, and hence its costs, do not exceed the anticipated levels upon which the HMO's premiums were based. This arrangement, which is used to impose some of the HMO's financial risk on participating providers and thus to help control unnecessary utilization of expensive health care services, also might be viewed as violating proposed regulation R4-21-301.D.1.

Furthermore, referral services, either for-profit or not-for-profit, that refer prospective patients to one or more providers, based on the stated needs of the patients and the qualifications or prices of the providers, may also violate this regulation if providers are required to pay a fee to the service for each referral. These services may provide valuable information to consumers about health care providers and thus may have a pro-competitive effect. Finally, this proposed regulation may interfere with certain franchise arrangements where providers pay a percentage of their fees to a franchisor in return for marketing, advertising services, and the use of a trade name.

Because PPOs, HMOs, other alternative health care delivery systems, referral services, and franchise arrangements may help to lower the cost of health care services, we urge the Board to re-examine its reasons for proposing regulation R4-21-301.D.1 to determine whether such organizations and arrangements pose the kinds of harm to the public that this fee-splitting regulation is intended to prevent. We believe that the reasons often given for prohibiting fee-splitting do not apply to these arrangements. We

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[13] This proposed regulation essentially restates Ariz. Admin. Comp. R. 4-21-04.A.1 (Dec. 31, 1979).

reach this conclusion by examining three rationales often given for prohibiting fee-splitting.

B. Rationales for Fee-Splitting Regulations

One justification typically offered for fee-splitting regulations is to prevent abuse of the special trust that a patient places in a practitioner to make appropriate referrals based on his or her independent professional judgment of the patient's best interests. Suppose, for example, an optometrist refers a patient to an ophthalmologist for further testing. The patient, because he or she may be relatively uninformed about eye diseases, unsure how to choose among competing ophthalmologists, and worried about his or her condition, may rely heavily on the optometrist's recommendation. The rationale for prohibiting fee-splitting here is that if, unbeknownst to the patient, the optometrist will receive a referral fee or kickback from the ophthalmologist,[14] the optometrist may, consciously or not, refer the trusting patient for unnecessary medical care. There is also a concern that the optometrist will refer the patient to the ophthalmologist who pays the highest referral fees, rather than to the most competent one.

A PPO which receives a percentage of fees from optometrists, however, does not pose this problem of unnecessary or inappropriate referral of patients because the PPO "referral" takes place after a PPO enrollee has already independently decided to seek optometric care. There is no doctor-patient relationship that can be used to influence a patient to see another doctor in order to generate a referral fee. Instead, the PPO merely provides PPO enrollees with a list of practitioners. Although enrollees may rely on PPOs, to some extent, to assemble competent panels,[15] such reliance is not comparable to a patient's reliance on an optometrist who makes an in-person referral to a specific practitioner in the course of a professional diagnosis. This is especially true if PPO enrollees can also choose practitioners outside the PPO panel and if enrollees understand the criteria used by PPOs to

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14 This is an example of fee-splitting among health care practitioners and is addressed by Ariz. Admin. Comp. R. 4-21-04.A.2 (Dec. 31, 1979) and proposed regulation R4-21-301.D.2, which we do not take a position on.

15 It is an open question whether a PPO program is liable for the quality of care provided by the panel of practitioners it has assembled.

assemble their provider panels, including any requirement that providers remit a percentage of their fees to the PPO. Consequently, we see little danger that PPO patients will receive inferior or unnecessary health care because of improper referrals.

If the Board finds that consumers are being deceived by PPO programs, requiring disclosures necessary to prevent such deception would be less restrictive of PPOs than proscribing a whole category of relationships with optometrists. Similarly, disclosures necessary to prevent any deception caused by HMOs, referral services, or franchise arrangements could be required.

A second rationale for prohibiting fee-splitting is that fee-splitting may increase costs to the patient. The concern is that a patient referral fee paid by a practitioner ultimately will be passed along to the patient in the form of higher fees charged by that practitioner. This is unlikely to be a problem with PPOs and HMOs because the prices charged by providers are a key part of a bargain negotiated in advance by third-party payers. Indeed, the PPOs and HMOs that are likely to succeed in the increasingly price-competitive health care industry are those that best help employers and insurers to cut health care costs.

A third rationale arises from the concern that fee-splitting may facilitate lay interference with the practice of optometry. The concern is that a lay person who shares in an optometrist's fees might be able to exert some control over the optometrist's professional practice to the detriment of the optometrist-patient relationship.[16] It does not appear, however, that an optome-

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16 A related rationale, sometimes advanced for prohibiting the splitting of fees, particularly between optometrists and lay persons, is that such a practice may lead to violations of statutes such as Ariz. Rev. Stat. Ann. § 32-1741 (Supp. 1984-1985), which prohibit anyone from practicing optometry without a license. It does not appear, however, that PPOs pose any danger of the unauthorized practice of optometry. The principal activities of PPOs consist of contracting with providers and with third-party payers and matching them with each other. PPOs do not diagnose or treat patients. In fact, other than providing patients with the names of preferred providers, most PPOs do not deal directly with patients. Consequently, we foresee little danger that PPOs will illegally engage in the practice of optometry. In the unlikely event that they do, the Board would be able to discipline violators of § 32-1741 on a case-by-case basis.

trist's affiliation with a PPO or an IPA-type HMO that receives or holds back a portion of the optometrist's fees necessarily poses any danger of interference with the optometrist's independent professional judgment.[17] Indeed, we believe that the participation of an optometrist in a PPO or HMO poses no greater danger of lay interference with an "optometrist's professional responsibilities and discretion" than the employment of the optometrist by a lay person or corporation, as contemplated by proposed regulation R4-21-301.E.

C. Proposed Regulation R4-21-301.A: Payments for the Solicitation or Steering of Patients

Proposed regulation R4-21-301.A also may inhibit the operation of some PPOs, HMOs, and other alternative health care delivery systems. This regulation provides, in part:

> An optometrist shall not employ, pay, or reward or agree to employ, pay, or reward in any manner any person or organization for services in soliciting or steering patients or patronage to himself or any other optometrist.[18]

For the same reasons that we have set forth above, we believe that the dangers sought to be avoided by this proposed regulation are not likely to occur when an optometrist affiliates with a PPO, HMO, or other alternative health care delivery system that receives or holds back a portion of the optometrist's fees.[19]

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17 See State ex rel. Board of Optometry v. Sears, Roebuck & Co., 427 P.2d at 129 (finding that an arrangement whereby an Arizona optometrist paid a percentage of his total net sales to Sears as rent did not give Sears any "control over the professional activities of the optometrist.")

18 This proposed regulation essentially restates Ariz. Admin. Comp. R. 4-21-02.A.1 (Feb. 29, 1980).

19 Arizona law prohibits optometrists from "employ[ing] . . . a solicitor to solicit business or soliciting from house to house or person to person." Ariz. Stat. Ann. § 32-1743(5) (Supp. 1984-1985). We do not believe that this statutory provision warrants regulations as broad as Ariz. Admin. R. 4-21-02.A.1 or proposed regulation R4-21-301.A, particularly in light of evolving law regarding advertising and solicitation by professionals. See, e.g., Zauderer v.

(Continued)

D. Conclusion

The views expressed in this letter are consistent with the conclusions of the Commission in American Medical Association that the AMA's fee-splitting restrictions

> preclude on their face a wide variety of professional ventures by physicians that may involve some financial or other type of association with non-physicians (be they lay persons or other health care professionals). It is difficult to see how such sweeping ethical proscriptions are needed to prevent deception or to prevent non-physicians from having undue influence over medical procedures . . . .

94 F.T.C. at 1018 (footnote omitted).

In sum, the harm typically sought to be avoided by fee-splitting regulations and regulations that prohibit optometrists from paying for the solicitation or steering of patients is not likely to occur where an optometrist affiliates with a PPO, HMO, or other alternative health care delivery system. For similar reasons, we believe that such harm is not likely to occur when an optometrist affiliates with a referral service or a franchisor. Since such organizations and arrangements can be procompetitive and can help to contain health care costs, we urge the Board to either repeal Ariz. Admin. R. 4-21-04.A.1 and R. 4-21-02.A.1 and not adopt proposed regulations R4-21-301.D.1 and R4-21-301.A, modify these regulations so that only conduct that truly poses a danger to the public is prohibited, or amend these regulations so that optometrists' basic contractual arrangements with PPOs, HMOs, other alternative health care delivery systems, franchisors, and referral services are exempt.[20]

Supreme Court of Ohio, 105 S. Ct. 2265 (1985).

[20] Arizona law prohibits optometrists from "giving or receiving rebates." 1985 Ariz. Legis. Serv. 922, 924, 928 (West) (to be codified at Ariz. Rev. Stat. Ann. §§ 32-1701(9)(b), -1743(4)). Because the meaning of a "rebate" under the statute is not clear and because of the low risk of harm to the public as outlined above, we likewise urge the Board to construe this section so as not to apply to contractual arrangements between optometrists and alternative health care delivery systems, referral services, or franchisors.

IV. Advertising Restrictions

As a part of the Commission's effort to foster competition among licensed professionals, it has examined the effects of public and private restrictions that limit the ability of professionals to engage in nondeceptive advertising.[21] Studies have shown that prices for professional goods and services are lower where advertising exists than where it is restricted or prohibited.[22] Other studies have also provided evidence that higher prices occur where advertising is restricted and that these restrictions do not change the quality of services available in the market place.[23] Therefore, to the extent that nondeceptive

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21 See, e.g., American Med. Ass'n, 94 F.T.C. at 1002-11. The thrust of the AMA decision, "that broad bans on advertising and solicitation are inconsistent with the nation's public policy," id. at 1011, is consistent with the reasoning of recent Supreme Court decisions involving regulation of advertising by professionals. See, e.g., Zauderer v. Supreme Court of Ohio, 105 S. Ct. 2265 (1985) (holding that an attorney may not be disciplined for soliciting legal business through printed advertising containing truthful and nondeceptive information); Bates v. State Bar of Arizona, 433 U.S. 350 (1977) (holding state supreme court prohibition on price advertising invalid under the First Amendment); Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council, 425 U.S. 748 (1976) (holding Virginia prohibition on price advertising by pharmacists invalid).

22 Bureau of Economics & Cleveland Regional Office, Federal Trade Commission, Improving Consumer Access to Legal Services: The Case for Removing Restrictions on Truthful Advertising (1984); The Case of Optometry, supra note 3; Benham & Benham, Regulating Through the Professions: A Perspective on Information Control, 18 J.L. & Econ. 421 (1975); Benham, The Effects of Advertising on the Price of Eyeglasses, 15 J.L. & Econ. 337 (1972).

23 The Case of Optometry, supra note 3; Muris & McChesney, Advertising and the Price and Quality of Legal Services: The Case for Legal Clinics, 1979 Am. B. Found. Research J. 179 (1979). See also Cady, Restricted Advertising and Competition: The Case of Retail Drugs (1976); McChesney & Muris, The Effects of Advertising on the Quality of Legal Services, 65 A.B.A.J. 1503 (1979).

advertising is restricted, higher prices and a decrease in consumer welfare may result. For this reason we believe that only false or deceptive advertising should be prohibited. Any other standard is likely to suppress the dissemination of potentially useful information and may contribute to an increase in prices.

Accordingly, we urge the Board to reconsider proposed regulation R4-21-301.B, which is one such rule that may suppress the dissemination of useful information. It provides:

> All cards, stationary, prescriptions, or advertising materials used by an optometrist must clearly identify the individual optometrist involved.

This proposed rule may inhibit advertising by chain firms or group practices by requiring that every associated optometrist be listed in each advertisement. We, of course, recognize the necessity of ensuring identification and accountability of individual practitioners within such a practice. However, this goal could be accomplished through several methods less burdensome than the one proposed in the rule. For example, the Board could require that the names of individual practitioners be conspicuously posted in the reception area of optometric offices and noted on bills, receipts, and patient records.

Finally, we also urge the Board to reconsider proposed regulation R4-21-302.B which provides:

> An optometrist shall not advertise as a specialist unless he or she has been certified by the American Academy of Optometry as a diplomate in that specialty or as a fellow in the College of Optometrists in Vision Development.

It may be appropriate for the Board to reserve the use of the word "specialist" for optometrists satisfying reasonable criteria.[24] We are concerned, however, that the proposed regulation may be interpreted by the Board or by practitioners to prohibit optometrists from conveying truthful, non-deceptive information about

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24 The Board should consider whether this proposed regulation may serve to foreclose advertising as a specialist by optometrists who may be certified by other legitimate certifying organizations.

their practices and their expertise. Such expertise may be acquired through education, training, or practice in a particular field, even though it does not lead to certification. For example, adoption of this proposed regulation may prevent an optometrist from truthfully stating that his or her practice is "limited to the prescribing and fitting of contact lenses" when he or she has not in fact been certified in that field. Consequently, we ask that the Board re-examine this provision to ensure that optometrists are not deterred from conveying truthful information to consumers.

We appreciate this opportunity to comment on the proposed regulations. Please let us know if we can be of any further assistance.

Sincerely,

Walter T. Winslow

Walter T. Winslow
Acting Director

cc: William J. White, Esq.
Assistant Attorney General, State of Arizona

COMMISSION AUTHORIZED

COMMENTS OF THE FEDERAL TRADE COMMISSION'S BUREAUS OF COMPETITION, CONSUMER PROTECTION AND ECONOMICS

CONCERNING THE DEVELOPMENT OF REGULATIONS PURSUANT TO THE MEDICARE AND MEDICAID ANTI-KICKBACK STATUTE

PRESENTED TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

(LRR-17-NI)

DECEMBER 18, 1987

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I. Introduction

Congress has directed the Secretary of Health and Human Services ("the Secretary") to "promulgate . . . regulations, specifying payment practices that shall not be treated as a criminal offense"[1] under the Medicare and Medicaid anti-kickback law, Section 1128B(b) of the Social Security Act,[2] and that shall not provide a basis for excluding providers from the Medicare or Medicaid programs under Section 1128(b)(7).[3] The staff of the Federal Trade Commission[4] is pleased to provide these comments in response to the Department of Health and Human Services' request for public comments before proposed regulations are published by the Secretary.[5] We urge the Secretary to adopt regulations that make clear that those involved in certain types of legitimate, pro-competitive arrangements -- which can produce cost savings for the Medicare and Medicaid programs or for the programs' patients -- are not considered to be in violation of Section 1128B(b)'s broadly worded prohibition of referral fees.

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[1] Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93, § 14, 101 Stat. 680, 697 (1987).

[2] 42 U.S.C. § 1320a-7b(b). Section 1128B of the Social Security Act consolidates what were Sections 1877 (Medicare anti-kickback provision) and 1909 (Medicaid anti-kickback provision) of the Social Security Act, 42 U.S.C. §§ 1395nn and 1396h. Pub. L. No. 100-93, § 4.

[3] 42 U.S.C. § 1320a-7(b)(7).

[4] These comments represent the views of the Federal Trade Commission's Bureaus of Competition, Consumer Protection, and Economics, and not necessarily those of the Commission itself or of any individual Commissioner. The Commission has, however, voted to authorize their submission.

[5] 52 Fed. Reg. 38,794 (Oct. 19, 1987).

II. Summary of Our Recommendations

We discuss below examples of several types of financial arrangements and practices that could be construed to violate the Medicare and Medicaid anti-kickback statute, but that are part of legitimate, pro-competitive health plans or other arrangements that may ultimately increase competition among health care providers. Such arrangements and practices can provide cost savings to the Medicare and Medicaid programs or to the programs' patients. These include business arrangements used by health maintenance organizations (HMOs), preferred provider organizations (PPOs), and referral services and business practices such as the referral of patients by providers to health care facilities owned by the providers and hospital waiver of Medicare deductibles and coinsurance payments.

We urge the Secretary to develop regulations that make clear that providers involved in these and similar financial arrangements and practices that are not likely to increase costs to the Medicare and Medicaid programs will not be considered to be in violation of Section 1128B(b), and will not be subject to criminal or civil sanctions.

III. Interest and Experience of the Federal Trade Commission

Our interest in this matter stems from our involvement in competition and consumer protection policy. The Federal Trade Commission is empowered under 15 U.S.C. § 41 et seq. to prevent unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce. Pursuant to this statutory mandate, the Commission encourages competition among members of the licensed professions to the maximum extent compatible with other state and federal goals. For more than a decade, the Commission has investigated the competitive effects of restrictions on the business arrangements of hospitals and state-licensed health professionals, including physicians, pharmacists, physical therapists, and others. Among the restrictions that we have examined are ones that, like Section 1128B(b), prohibit the payment of rebates and referral fees.[6] Our goal has been to identify and seek the removal of those restrictions that impede competition, increase costs, and harm consumers without providing substantial countervailing benefits.

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[6] Letter from Janet M. Grady, Regional Director, San Francisco Regional Office, Federal Trade Commission to Hon. Chuck Hardwick, Speaker of the Assembly of the State of New Jersey (May 21, 1987); Letter from Walter T. Winslow, Acting Director, Bureau of Competition, Federal Trade Commission to H. Fred Varn, Executive Director, Florida Board of Dentistry (Nov. 6, 1985); Letter from Walter T. Winslow, Acting Director, Bureau of Competition, Federal Trade Commission to George M. Sanchez, O.D., President, Arizona State Board of Optometry (Oct. 17, 1985). Copies of these letters are available from the Federal Trade Commission's Office of Public Affairs.

IV. The Medicare/Medicaid Anti-Kickback Statute and its Purpose

The Medicare and Medicaid anti-kickback statute provides that a person is guilty of a felony (1) whenever he knowingly solicits or receives "any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind" in return for referring an individual for goods or services covered by Medicare or Medicaid or in return for purchasing or arranging the purchase of such goods or services, or (2) whenever he knowingly offers or pays any remuneration to induce such referral or purchase.[7]

Congress adopted the original version of this provision in 1972, and made violation of it a felony in 1977, in large part because it determined that the condemned practices "contribute significantly to the cost of the [Medicare and Medicaid] programs."[8] A concern is that kickbacks can encourage fraudulent referrals for unnecessary care. According to Congress, this type of fraudulent practice

> cheats taxpayers who must ultimately bear the financial burden of misuse of funds in any government-sponsored program. It diverts from those most in need, the nation's elderly and poor, scarce program dollars that

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[7] Section 1128B(b) of the Social Security Act, 42 U.S.C § 1320a-7b(b).

[8] H.R. Rep. No. 95-393 (II), 91st Cong., 1st Sess., reprinted in 1977 U.S. Code Cong. & Ad. News 3039, 3055.

were intended to provide vitally needed quality health services.[9]

V. Arrangements That Should Not Be Considered in Violation

In connection with our efforts to promote competition in the health care sector of the economy, we have observed several types of business arrangements and practices that could be construed to violate Section 1128B(b), but which we believe are pro-competitive, and in many cases are likely to help control Medicare and Medicaid costs. These include business arrangements involving HMOs, PPOs, and referral services, and business practices such as the referral of patients by providers to health care facilities owned by the providers and hospital waiver of Medicare copayments and deductibles. We explain below how each of these types of arrangements and practices could be construed to violate Section 1128B(b), and why, nonetheless, they are pro-competitive, and may benefit third-party payors such as Medicare and Medicaid. Although we are not aware of any prosecutions under Section 1128B(b) of providers involved in these types of arrangements and practices, we are concerned that some people may be discouraged from using pro-competitive arrangements because of

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[9] Id. at 3047.

the severe penalties to which violators of Section 1128B(b) are subject.[10]

A. Alternative Health Care Delivery Systems

Health maintenance organizations and preferred provider organizations are health care delivery systems that are marketed to employers, unions, and other groups as alternatives to traditional fee-for-service programs offered by third-party payors such as commercial health insurers. We believe that alternative delivery systems can be pro-competitive forces in the health care market.[11] For example, both HMOs and PPO programs typically have built-in incentives to control health care costs and thus provide cost-effective alternatives to traditional systems for the financing and delivery of health care.[12] In

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[10] Violators are subject to a maximum of five years in prison and a $25,000 fine, 42 U.S.C. § 1320a-7b(b), and exclusion from participation as providers in the Medicare and Medicaid programs, 42 U.S.C. § 1320a-7(b)(7).

[11] See, e.g., Health Care Management Associates, 101 F.T.C. 1014 (1983) (advisory opinion concerning PPO program); Letter from James C. Miller III, Chairman, Federal Trade Commission, to Representative Ron Wyden (July 29, 1983) (commenting favorably on proposed federal legislation which would have exempted PPOs from the coverage of certain state laws and regulations).

[12] See e.g., Epstein, Begg and McNeil, The Use of Ambulatory Testing in Prepaid and Fee-for-Service Group Practices, 314 N. Engl. J. Med. 1089 (1986); Johnson and Aquilina, The Impact of Health Maintenance Organizations and Competition on Hospitals in Minneapolis/St. Paul, 10 J. of Health Politics, Policy and Law 659 (1986); Bureau of Economics, Federal

addition, as "bulk" purchasers of hospital and medical services, HMOs and PPOs can increase competition among providers of such services, who vie for contracts with them.

Although they exist in many different forms, all PPO programs involve a series of contractual arrangements between "preferred" health care providers and an intermediary, such as an insurer or self-insured employer, that acts as a third-party payor of health care benefits. PPO programs often attempt to select preferred providers for their ability to deliver quality health care at a low cost. Enrollees in PPO programs usually are given financial incentives, typically waivers of copayments and deductibles, to encourage them to use these lower cost preferred providers.

HMOs are similar, in many respects, to PPO programs. Both types of arrangements use a limited panel of health care providers and provide coverage for a wide range of health care services. HMOs differ from PPO programs in that HMOs deliver these services directly to enrollees by employing or contracting with health care providers, as well as by undertaking the insurance function that third-party payors provide in PPO arrangements. In addition, HMOs generally provide coverage only if enrollees obtain their health care services from these

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Trade Commission, Staff Report on the Health Maintenance Organization and Its Effects on Competition (1977).

participating providers. Most PPO programs, by contrast, provide coverage for use of non-participating providers, albeit at a higher out-of-pocket cost to enrollees.

Some of the contractual arrangements used by HMO and PPO programs, however, may involve legitimate payments that nevertheless could be construed to violate Section 1128B(b). For example, some PPO programs require participating providers to remit to the PPO a percentage of the fees earned from treating PPO patients. This is one method used for funding a PPO's administrative expenses. Although not all PPOs are financed in this manner, this type of PPO program may be attractive to many providers because the fees they pay to the PPO are directly proportional to the benefits (i.e., the number of referred patients) that they receive from participating in the program. Because the financial success of a new program often is uncertain, providers may prefer to participate in such PPO programs that "meter" the benefits to them rather than in programs that require substantial up-front capital contributions or annual charges. On its face, this type of financial arrangement might be characterized as a payment by the provider of a "kickback" to the PPO program in order to induce the PPO to refer patients to the provider, in violation of Sections 1128B(b)(1)(A) and (2)(A)[13] if Medicare or Medicaid funds are involved.

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[13] 42 U.S.C. §§ 1320a-7b(b)(1)(A) and (2)(A).

Certain financial arrangements used by HMOs could also be construed to violate Section 1128B(b). For example, some HMOs, particularly those known as the IPA (individual practice association) type, hold back a certain percentage of each individual provider's fees for services rendered, in order to create a reserve to pay for an unexpectedly high use of services by the entire subscriber population. This "holdback" fund is later distributed pro rata to the providers if the program's aggregate utilization levels, and hence its costs, do not exceed the anticipated levels upon which the HMO's premiums were based. This arrangement is used to spread some of the HMO's financial risk over its participating providers, and gives providers an additional incentive to help control unnecessary use of expensive health care services. The distribution of the holdback fund could be considered the payment of a rebate in violation of Section 1128B(b).

We believe, however, that these types of HMO and PPO arrangements are unlikely to increase payments by the Medicare and Medicaid programs[14] because such arrangments do not provide incentives for making referrals for unnecessary or inappropriate medical care. For example, the PPO program described above,

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[14] We understand that Medicare currently contracts with HMOs to provide health care to some of the program's patients, 42 U.S.C. § 1395mm, and that it also is considering using PPO arrangements to provide care to patients.

while perhaps technically making a referral and receiving a fee in return, does not itself suggest or recommend medical care. The PPO program provides only a list of preferred health care providers, from which patients can choose. Thus, the PPO program is not in a position to refer patients for unnecessary care in order to increase the amount of fees paid to the PPO by providers. Furthermore, the physician or other health care provider who actually recommends medical care to a PPO patient does not receive any referral fee under the arrangement we have described. For the same reasons, the HMO "holdback" arrangement described above is unlikely to result in unnecessary referrals and higher costs to the Medicare and Medicaid programs. Indeed, rather than encouraging referrals for unnecessary care, the holdback, which providers do not receive if program costs exceed anticipated levels, encourages providers to hold down costs and thus conserve program resources.

Use of alternative delivery systems such as HMOs and PPOs can actually reduce the costs of third-party payors, such as Medicare and Medicaid. Most HMO and PPO programs are designed to control health care costs so that the programs can be successfully marketed to cost-conscious groups. The programs that are likely to succeed in the increasingly price-competitive health care industry are those that best help employers,

insurers, and other third-party payors cut health care costs.[15] HMOs and PPOs typically attempt to control costs in several ways. First, many HMO and PPO programs are "bulk" purchasers of medical services and are often able to negotiate fees that are lower than providers' usual charges. Second, PPO programs often seek to contract with providers who have demonstrated a propensity to control expenditures. Third, many PPOs and HMOs use innovative methods to control costs, such as risk-sharing among providers and incentives for enrollees to use preferred providers. Finally, many HMO and PPO programs provide strict controls on utilization.

We believe that the contractual payments made to HMOs and PPOs that we have described above should be analyzed in the context of the overall cost-saving potential of the programs of which they are a part. This is very similar to the approach taken by Congress in 1986, when it decided to exempt from Section 1128B(b) what otherwise might be construed as "kickbacks" made by vendors to group purchasing agents, as long as certain disclosure and other requirements are met.[16] Congress found that "to cover costs," group purchasing organizations (GPOs) acting on behalf of

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[15] Contracts between HMO and PPO programs and employers, for example, are often subject to renewal or cancellation on an annual basis. Those programs that fail to keep costs down are at risk of losing these contracts to other, more efficient, health care plans.

[16] Section 1128B(b)(3)(C) of the Social Security Act, 42 U.S.C. § 1320a-7b(b)(3)(C).

participating hospitals and other organizations sometimes "require vendors from whom they purchase services or supplies to pay them a fixed percentage of the value of the business that they refer to the vendors."[17] In recommending that such payments be exempt from Section 1128B(b), the House Budget Committee stated:

> The Committee believes that GPO's can help reduce health care costs for the government and the private sector alike by enabling a group of purchasers to obtain substantial volume discounts on the prices they are charged. The Committee understands that the amount of the price reductions exceeds the fees the vendors must pay the GPO's. The Committee can see no justification for prohibiting such cost-saving arrangements . . . .[18]

Thus, Congress determined that the GPOs, when examined in the context of their overall effect on the market, are likely to reduce health care costs. As we have stated, the overall structure of PPOs and HMOs can also help reduce health care costs for the government and the private sector. Payment mechanisms used to cover the costs of PPO programs and HMOs, like the percentage payment system used by GPOs, should be permitted in order to encourage cost-saving arrangements.

In order to encourage the development of programs like HMOs and PPOs that are likely to reduce costs, increase consumer welfare, and benefit the Medicare and Medicaid programs, we urge

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[17] H.R. Rep. No. 99-727, 99th Cong., 2nd Sess., reprinted in 1986 U.S. Code Cong. & Admin. News 3607, 3662.

[18] Id. at 3663.

that the Secretary specifically state, in the proposed regulations, that participation in HMO and PPO programs will not be considered to violate Section 1128B(b).

B. Referral Services

Referral services, which can be either for-profit or not-for-profit, refer prospective patients to one or more providers, based on the stated needs of the patients and the qualifications or prices of the providers. These services could also be construed to violate Section 1128B(b) if providers are required to pay a fee to the service for referrals. However, we believe that referral services are also unlikely to raise the costs of the Medicare and Medicaid programs.

Referral services typically make available a wide variety of information on the providers to whom they refer patients. Such information can promote competition by enabling patients to compare fees and services offered by providers. For example, a referral service can inform patients as to which providers will accept Medicare assignment. The fees paid to referral services are unlikely to provide an incentive for anyone to refer patients for unnecessary care. This is because, like the PPO arrangement described earlier, the entity receiving the fee, the referral service in this case, does not recommend or suggest that the

patient obtain medical care. Indeed, referral services are most often used by patients who "self-refer;" that is, patients who have decided on their own to seek medical care.

For these reasons, we urge the Secretary specifically to state, in the proposed regulations, that participation in referral services will not be considered to violate Section 1128B(b).

C. Ownership Interests

Referral of patients by a provider to an entity in which the provider has a financial interest could also be viewed as a violation of Section 1128B(b). For example, a physician may refer a patient to a laboratory in which he has a partial ownership interest. Presumably, the physician will be entitled to some of the profits generated by the laboratory, some of which may be attributable to that particular referral. Such profits could be construed as "any remuneration . . . [received] directly or indirectly . . . in cash or in kind" in return for referring that patient to that laboratory.[19]

While the benefits of allowing health care practitioners to refer patients to entities in which they have financial interests

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[19] 42 U.S.C. § 1320a-7b(b).

may not be as obvious as those of alternative delivery systems, such practices may have several pro-competitive effects. First, established practitioners in a community might identify particular health care needs in their area, such as, for example, a certain type of medical laboratory. Prohibiting physicians from referring Medicare and Medicaid patients to this laboratory may make them reluctant to invest time, money and experience in such a project.

Second, a practitioner who refers patients for further care to an entity in which he has invested, for example, a physical therapy practice, may be better able to assure continued high quality care for those patients. This is because an investment interest may lead to a stronger, more permanent working relationship between the referring practitioner and the entity in which he has a financial interest.

It can be argued that allowing practitioners to refer patients to entities in which they have financial interests does increase the risk of referrals for unnecessary, inappropriate, or more expensive care. But there are many other common practices in the health care field that also create such a risk that have never been considered to be unlawful. For example, when one practitioner refers a patient to another practitioner in the same professional service corporation or partnership, the referring practitioner will usually share in any profits generated by the

fees paid to the second practitioner.[20] Multispecialty clinics can be a highly efficient way of providing health care services, as can ownership of entities that provide ancillary services. We do not believe that Congress intended to outlaw these practices in the context of the Medicare and Medicaid programs.[21]

The types of practices that could be construed to violate Section 1128B(b) lie on a continuum in terms of their potential to increase the costs of the Medicare and Medicaid programs. At one end of this continuum there are fraudulent "kickbacks" for referrals of Medicare and Medicaid patients, which are illegal. At the other end are situations such as a physician who owns a few shares of stock in a pharmaceutical company. That physician is not likely to be considered in violation of Section 1128B(b) when he prescribes medications manufactured by that company

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[20] This problem may be most evident when a practitioner recommends that he himself provide additional services.

[21] We note that Medicare and Medicaid officials have taken the position that referrals to entities in which the provider has an ownership interest may not violate the law. See Letter from Irv Cohen, Deputy Director, Office of Program Validation, Health Care Financing Administration (Nov. 25, 1980) ("We do not believe that physician referrals to an entity in which the referring physician maintains an ownership (or other investment) interest would, per se, violate the illegal remuneration provisions of section 1877 [predecessor to Section 1128B of the Social Security Act, dealing with Medicare]."); Letter from Martin L. Kappert, Director, Bureau of Quality Control, Health Care Financing Administration (Dec. 10, 1980) (physician's ownership interest in a medical supply company to which the physician may refer his patients does not violate Section 1909 (predecessor to Section 1128B(b) of the Social Security Act, dealing with Medicaid)) (addressees of letters not made public). We beleive, however, that regulations under Section 1128B(b) should make this explicit.

because this practice is unlikely to result in unnecessary prescriptions and thereby increase costs. The problem with which the Secretary is now faced is where to draw the line along this continuum, between those arrangements that should be considered in violation of Section 1128B(b) and those that should not. We believe that the benefits of allowing practitioners to refer patients to health care facilities they own suggest that, in drawing this line, the Secretary should permit such practices.

To reduce the risk of encouraging unnecessary referrals, and to remedy any deception of patients, the Secretary may want to consider adopting regulations under Section 1128B(b) to require that practitioners disclose to patients any ownership interest they have in an entity to which they are referring the patient. Although it is uncertain how much disclosure will reduce Medicare and Medicaid costs, it could provide the patient with information that may aid in the decision whether to use the recommended provider.[22] If a disclosure requirement is adopted, care should be taken to avoid disclosure requirements that impose unnecessary costs on providers.[23]

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[22] Similar disclosure requirements exist in the laws of some states. See, e.g., California Bus. & Prof. Code § 654.2, which requires that physicians disclose in writing to patients any financial interest they have in facilities to which patients are referred, and inform patients that they do not have to use the provider the physician has selected.

[23] The Secretary might also consider regulations that state that Section 1128B(b) will be applied where the percentage of the profits the practitioner receives from the entity in which the practitioner has a financial interest varies with the number of patients referred, or the dollar amount of services referred, or where the investment interest is nothing more than a sham to cover up an agreement by the practitioner to refer patients to the entity for compensation substantially in excess of any legitimately earned profits.

We urge the Secretary specifically to state, in the proposed regulations, that an ordinary return on invested capital will not be considered remuneration within the meaning of Section 1128B(b).

D. Waivers of Deductibles for Medicare Part A

Under Medicare Part A, which provides for payment for inpatient hospital services, Medicare deducts from its payments to hospitals amounts that Medicare permits hospitals to collect from the Medicare patient as coinsurance and deductibles.[24] Some hospitals waive coinsurance and deductible amounts as a marketing technique to attract patients to use their hospitals. Such a waiver could be construed as a payment by the hospital to induce the Medicare patient to use the hospital's

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[24] Apparently, there is no direct statutory requirement that hospitals collect these coinsurance and deductible amounts from patients. Letter from Richard P. Kusserow, Inspector General, U.S. Department of Health and Human Services to Stephen S. Trott, Assistant Attorney General, Criminal Division, U.S. Department of Justice (April 17, 1985).

services, in violation of Section 1128B(b).[25] We believe that waivers of deductible and coinsurance amounts should not be treated as unlawful because they can provide price competition among hospitals. This competition can result in lower prices to Medicare patients and therefore benefit consumers.

Although allowing hospitals to waive these payments may not raise the cost to Medicare for a given hospitalization,[26] overall costs could increase because some patients whose deductible and coinsurance payments are waived by hospitals, will opt for hospitalizations that might not be medically necessary. Congress may have provided for deductible and coinsurance amounts in part to provide incentives for patients to question the advisability of inpatient hospital care.[27]

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[25] See West Allis Memorial Hosp., Inc. v. Bowen, 660 F. Supp. 936 (E.D. Wis. 1987) (preliminary injunction sought by hospital to enjoin competitor hospital's waiver of Medicare deductibles and coinsurance amounts, on grounds that such waiver violated Medicare anti-kickback statute, denied by court).

[26] Hospitals are currently reimbursed by Medicare under a prospective payment system. Pursuant to a specific "diagnosis related group" (DRG) for each patient, hospitals are paid a fixed amount by Medicare regardless of the actual costs incurred by the hospital for treating that particular patient. The hospital is not permitted to bill Medicare for a higher amount to cover the cost of waiving deductibles or coinsurance amounts.

[27] Kusserow, supra, note 24 at 4. However, we understand that the Department of Health and Human Services' Inspector General believes that other mechanisms exist, such as Medicare contracts with quality control peer review organizations, to effectively control overutilization of hospitals. Id. at 5-6.

We suggest that the Secretary consider whether the potential increase in competition and savings to Medicare patients that can occur from waiver of Medicare coinsurance and deductible amounts outweighs the possible overutilization of hospital care that may be caused by such a waiver. If the Secretary determines that the benefits outweigh the costs, then we suggest that the Secretary adopt regulations that make clear that such waivers of Medicare deductibles and coinsurance amounts do not violate Section 1128B(b).[28]

E. Other Arrangements

The specific types of arrangements that we have described are by no means an exhaustive list of the types of arrangements that, although they could be viewed as violating Section 1128B(b), are likely to provide pro-competitive benefits to the

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28 We note that the Inspector General does not support an exemption for waivers of coinsurance amounts by Medicare Part B providers (providers of medical services other than inpatient hospital services). In part, this is because Part B providers are reimbursed on a fee-for-service basis, with the resulting possibility that the cost of waiving coinsurance amounts may be passed on to the Medicare program. Id. at 4-5. If, in the future, reimbursements to Part B providers are determined on a DRG basis, we suggest that the Secretary follow the same approach regarding waivers by Part B providers that we have outlined regarding Part A providers. In the meantime, the Secretary should consider whether the pro-competitive advantages of allowing Part B providers to waive Medicare deductibles and copayments outweigh the need for criminal sanctions to prevent such providers from passing through the cost of such waivers to the Medicare program.

and Medicaid programs and their patients. The health
:or of the economy is constantly generating innovative
that facilitate competition among providers or that are
to be competitive by controlling costs and providing
:are. There are likely to be additional types of pro-
ive programs, which, like the ones we have described, may
ancillary financial arrangements that could be construed
te Section 1128B(b). As long as these ancillary
ents, when viewed in the context of the pro-competitive
of which they are a part, are not likely to impose costs
:edicare and Medicaid programs, including costs for
:ary care, they should not be prohibited.

suggest that the Secretary closely examine such
ients in light of the goals of Section 1128B(b). We urge
:etary to make clear that if, when balanced against the
petitive and cost-saving effects of the entire program,
rrangements are not likely to raise the costs of the
e and Medicaid programs, they will not be considered to
Section 1128B(b).

<u>:clusion</u>

: have attempted to provide examples of several types of
:al arrangements and practices in the health care sector of

the economy that could be construed to violate the Medicare and Medicaid anti-kickback statute, but that are part of pro-competitive health plans or other arrangements that may ultimately provide cost savings to the Medicare and Medicaid programs or to the programs' patients. The specific arrangements we have identified involve HMOs, PPOs, and referral services. The specific practices we have identified include the referral of patients by providers to health care facilities owned by the providers and hospital waiver of Medicare deductibles and coinsurance payments. Many of these arrangements and practices are not likely to raise Medicare and Medicaid costs, and thus are not the type of arrangements and practices that Congress has sought to prohibit. Consequently, we urge the Secretary to develop regulations pursuant to Section 1128B(b) that make clear that providers involved in these and similar financial arrangements and practices that are not likely to raise costs to the Medicare and Medicaid programs, will not be subject to criminal prosecution under Section 1128B(b) and to exclusion from the Medicare and Medicaid programs under Section 1128(b)(7).

We appreciate this opportunity to provide these comments. Please let us know if we can be of any further assistance.

Bureau of Competition
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

November 6, 1985

H. Fred Varn, Executive Director
Florida Board of Dentistry
130 North Monroe St., Suite 15
Tallahassee, Florida 32301

Re: Docket No. 85-DS-05

Dear Mr. Varn:

The Federal Trade Commission's Bureaus of Competition, Consumer Protection, and Economics[1] are pleased to respond to the request by the Florida Attorney General's Office for comments concerning the Petition for Declaratory Statement filed with the Board of Dentistry of the Florida Department of Professional Regulation in August 1985 by Harvey Adelson, D.D.S. (Docket No. 85-DS-05) (hereinafter "the Petition").

The Federal Trade Commission is empowered under 15 U.S.C. § 41 et seq. to prevent unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce. Pursuant to its statutory mandate, the Commission encourages competition among members of the licensed professions to the maximum extent compatible with other legitimate state and federal goals. For several years, the Commission has been investigating the competitive effects of restrictions on the kinds of business arrangements that state-licensed professionals, including optometrists, dentists, lawyers, physicians, and others are permitted to use in their respective practices. Our goal is to identify and seek the removal of those restrictions that impede competition, increase costs, and harm consumers without providing substantial countervailing benefits.

The Board has been asked in the Petition to interpret Fla. Stat. Ann. § 466.028(1)(n) (West Supp. 1985), which provides that the following conduct shall be grounds for disciplinary action:

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1 These comments represent the views of the Bureaus of Competition, Consumer Protection, and Economics of the Federal Trade Commission and do not necessarily represent the views of the Federal Trade Commission or any individual Commissioner. The Federal Trade Commission, however, has reviewed these comments and has voted to authorize their presentation.

> Exercising influence on the patient or client in such a manner as to exploit the patient or client for the financial gain of the licensee or of a third party, which includes, but is not limited to, the promotion or sale of services, goods, appliances, or drugs and the promoting or advertising on any prescription form of a community pharmacy unless the form also states "This prescription may be filled at any pharmacy of your choice."; or paying or receiving any commission, bonus, kickback or rebate; or engaging in any split-fee arrangement in any form whatsoever with a dentist, organization, agency, or person, either directly or indirectly, for patients referred to providers of health care goods and services, including, but not limited to, dentists, hospitals, nursing homes, clinical laboratories, ambulatory surgical centers, or pharmacies. The provisions of this paragraph shall not be construed to prevent a dentist from receiving a fee for professional consultation services.

Specifically, the Petition asks:

> Does a violation of Section 466.028(1)(n), F.S. occur when a dentist makes a patient referral to another dental office where:
>
> (1) The referring dentist has an ownership interest in the referred dental office . . . .[2]

The purpose of this letter is to suggest certain factors that may assist the Board in determining whether § 466.028(1)(n) prohibits dentists from referring patients to other dental practices in which they have an ownership interest. While we recognize the potential conflict of interest created by such investments, we believe that construing this statute to permit such investments where adequate disclosure is made to patients, rather

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2 Petition, ¶ 5. We do not comment on any other questions posed in the Petition. We also assume that the dentist's percentage of the profits in the "referred dental office" does not vary with the number of patients he or she refers to that dental office.

than banning them altogether, may provide valuable procompetitive and consumer benefits.

It does not appear that dentists' investments in other dental practices to which they refer patients are explicitly prohibited by a plain reading of § 466.028(1)(n). The statute prohibits "exercising influence on the patient . . . in such a manner as to exploit the patient . . . for the financial gain of the licensee." Many activities by dentists, such as the recommendation and subsequent provision of dental care, involve influencing the patient in a manner that may result in the financial gain of the dentist. The statute, however, prohibits such conduct only when it exploits the patient. Exploitation connotes taking unfair advantage of patients, which, we suggest, does not occur merely because a dentist refers patients to a dental practice in which he or she has a financial interest, particularly where, as we discuss later, this interest is fully disclosed to the patient. As an example of exploitation, this statute does use the broadly worded language "any split-fee arrangement in any form whatsoever with a dentist . . . either directly or indirectly." However, the terms "commission, bonus, kickback or rebate" and "split-fee arrangement" all suggest a situation in which a dentist shares in the fees paid to another dental practice by each patient referred to the other practice by the first dentist. An ownership interest, by contrast, involves the potential receipt of "profits" or "dividends," words which the legislature did not use, and which are not conditioned on the making of any referrals.[3]

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3 Congress has enacted a provision similar to § 466.028(1)(n) in the context of the Medicare program. It provides that it is a felony whenever a person

> knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind --
>
> (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this subchapter . . . .

42 U.S.C. § 1395nn(b)(1) (1982). See also 42 U.S.C. § 1396h (similar statute governing Medicaid program). Although this statute appears broader than the Florida statute because it covers "any remuneration," it has apparently never been

(Continued)

Since the statute does not explicitly prohibit the practice in question, we suggest that the Board, in determining whether this statute implicitly prohibits the practice, look for guidance to the policy reasons behind this fee-splitting prohibition. We believe that fee-splitting statutes typically are designed to prevent a dentist from receiving undisclosed kickbacks for patient referrals because some dentists may recommend unnecessary dental care or care from practitioners who charge excessive fees or who are not necessarily the most competent, solely because such practitioners kick back a portion of their fees. The potential harm is that patients, many of whom know little about dental disease, have little direct information about practitioners, are worried about their health and are unaware of any potential conflict of interest, are likely to rely heavily on such recommendations by their dentists.

Investments by dentists in other dental practices to which they refer patients do not, we believe, pose the same risk of exploitation as direct payments for referrals. Indeed, the potential harm to the public of dentists' investments in other dental practices to which they refer patients is akin to that of many other common practices in the medical and dental fields that are not generally considered exploitative of patients.[4] For

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applied to prevent a health care provider from referring patients to businesses or medical practices in which the provider has an ownership interest. The Health Care Financing Administration, in fact, issued an opinion letter in 1980 regarding a proposal by a group of physicians to form a limited partnership for the purpose of providing out-patient radiology services to the general public. The opinion stated: "We do not believe that physician referrals to an entity in which the referring physician maintains an ownership (or other investment) interest would, per se, violate the illegal remuneration provisions of section 1877 [of the Social Security Act, 42 U.S.C. § 1395nn]." Letter from Irv Cohen, Deputy Director, Office of Program Validation, Health Care Financing Administration (Nov. 25, 1980). See also Letter from Martin L. Kappert, Director, Bureau of Quality Control, Health Care Financing Administration (Dec. 10, 1980) (physician's ownership interest in a medical supply company to which the physician may refer his patients does not violate 42 U.S.C. § 1395nn).

4 The problem of self-dealing may be most evident when a dentist recommends that he himself provide additional dental services to the patient. Indeed, the danger of exploiting patients may be greater in that situation than when the dentist, for example, refers the patient to a periodontist in a

(Continued)

example, when one dentist refers a patient to another dentist in the same professional service corporation or partnership, the referring dentist will share in any profits generated by the fees paid to the second dentist. The division of profits will depend on the distribution of shares in the professional service corporation or partnership. Presumably, this would not be found to violate § 466.028(1)(n). Furthermore, allowing dentists to invest in other dental practices seems little different from allowing dentists to invest in dental laboratories, dental equipment manufacturers, pharmaceutical companies, or pharmacies which they patronize or which they recommend or require (i.e., by prescription) that their patients patronize. It might be helpful to the Board, in determining whether § 466.028(1)(n) allows dentists to invest in other dental offices to which they refer patients, to consider whether these other practices have resulted in any exploitation of patients.[5]

Restricting the ability of dentists to invest in other dental practices to which they refer patients may have several competitive effects. First, a dentist who refers some patients for further care to a dental practice in which he or she has invested, may be better able to assure continued high quality care for those patients. This is because an investment interest may lead to a stronger, more permanent working relationship between the referring dentist and the other dental practice. In addition, a dentist who invests his or her money in another dental practice, like any long-term investor, has a direct economic interest in insuring that the practice will provide quality services. This is because a dental practice that acquires a reputation for performing unnecessary or poor quality dental care is likely to lose patients as well as referral business from other providers and may ultimately lose money.

Second, prohibiting dentists from investing in other dental practices to which they refer patients may limit the ability of established dentists to use their experience to reduce the costs of providing dental care. For example, their experience may

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practice in which the referring dentist has a partial ownership interest. This is because of the more attenuated financial reward in the latter case and because a referred patient may feel more comfortable exploring alternative sources of care.

5 Militating against exploitation of patients in these situations is the fact that the dentist's reputation and possibly his or her malpractice liability is at stake whenever he or she refers a patient to another dentist or to a laboratory, or whenever he or she prescribes a drug.

enable them to organize a new practice efficiently by procuring office space and equipment and hiring dentists and office personnel in a manner that reduces costs and thus may result in lower prices for dental care.

Third, such a prohibition may limit the ability of dentists to use their experience to help satisfy the particular dental care needs of a community. Established general practice dentists are in a unique position to detect and respond to a need, for example, for a new dental practice that offers care in certain specialties, in certain locations, or at more convenient hours.

Finally, because such a prohibition would eliminate an entire category of potential investors, it may reduce the amount of equity capital available for entry into the dental services market by recent dental school graduates as well as by innovative types of practices that may offer newer or better dental services or discounted prices to the public. The effect of such a prohibition may be particularly significant since shareholders in dentists' professional service corporations are already limited by law to licensed dentists.[6]

Considering the possible competitive harm caused by a broad ban on dentists' investments in other dental practices to which they refer patients, and absent evidence that the practice in question has proved to be exploitative, we suggest that a simple disclosure to patients could, at least in most cases, prevent the exploitation of patients that § 466.028(1)(n) was designed to address. For example, the Board could interpret this statute to require a dentist who refers a patient to another dental practice in which he or she has an ownership interest to fully disclose the nature of that interest to the patient, perhaps in writing. A patient who is so informed can decide for himself or herself whether, in light of all the circumstances, the potential conflict of interest may have adversely influenced the dentist's judgment.

The approach we recommend is similar to the position adopted by the American Medical Association regarding the referral of patients to hospitals:

> [A] physician may own or have a financial interest in a for-profit hospital, nursing home or other health facility, such as a free-standing surgical center or emergency

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6 Fla. Stat. Ann. § 621.09 (West 1977).

> clinic. However, the physician has an affirmative ethical obligation to disclose his ownership of a health facility to his patient, prior to admission or utilization.[7]

In addition to requiring disclosure, it appears that the Board, pursuant to § 466.028(1)(n), can avoid exploitation or abuse by disciplining dentists on a case-by-case basis in all conflict-of-interest situations where dentists in fact "exploit the patient or client for the financial gain of the licensee." For example, the Board could presumably discipline a dentist for referring a patient for unnecessary dental care to another dental practice in which the referring dentist has a financial interest. It might also be appropriate for the Board to discipline a dentist who has invested in another dental office when the percentage of the profits from that other office varies with the number of patients he or she refers to that office. Finally, the Board could apparently also discipline a dentist if an investment in another dental practice is nothing more than a sham to cover up

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7 § 4.04, Current Opinions of the Judicial Council, American Medical Association (1984). See also House of Delegates of the American Medical Association, Report of the Judicial Council, Conflict of Interest Guidelines (December 1984).

A similar disclosure approach has been taken by some states. For example, California Bus. & Prof. Code § 654.1 (Deering Supp. 1985) provides that physicians, dentists, and other health care providers

> may not refer patients . . . to any clinical laboratory . . . in which the licensee has any membership, proprietary interest, or co-ownership in any form, or has any profit-sharing arrangement, unless the licensee at the time of making such referral discloses in writing such interest to the patient . . . . The written disclosure shall indicate that the patient may choose any clinical laboratory for purposes of having any laboratory work or assignment performed.

California law also provides that a referral to a laboratory in such a situation is unlawful "if the prosecutor proves that there was no valid medical need for such referral." Cal. Bus. & Prof. Code § 650 (Deering Supp. 1985). See Opinion No. 84-806, Attorney General of the State of California (Feb. 8, 1985).

an agreement by the dentist to refer patients to the other practice for compensation substantially in excess of any legitimately earned profits. For example, if a dentist has invested a relatively small percentage of the equity capital in a dental practice but receives a relatively large percentage of the profits, it may indicate that he or she is being compensated for referring patients rather than as a return on a bona fide investment.[8]

For the foregoing reasons, we suggest that the Board consider whether § 466.028(1)(n) allows dentists to refer patients to other dental practices in which they have an ownership interest where adequate disclosure of such interest is made to patients.

We appreciate this opportunity to comment on the Petition. Please let us know if we can be of any further assistance.

Sincerely yours,

Walter T. Winslow

Walter T. Winslow
Acting Director

cc: John E. Griffen, Esq.
Assistant Attorney General
State of Florida

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8 In certain circumstances, abuses by health care providers of their patients' trust may be a deceptive act or practice or unfair method of competition in violation of § 5 of the Federal Trade Commission Act. 15 U.S.C. § 45 (1982).

MINNESOTA BOARD OF MEDICAL EXAMINERS UPDATE

Spring 1988

NEWSLETTER INAUGURATED

The publication of this newsletter has been a stated goal of the Board and we are pleased to send you this inaugural edition. Our plans call for this newsletter to be a bi-yearly publication. It is the intent of the Board to keep our licentiates (i.e. M.D.'s, D.O.'s, P.T.'s, and P.A.'s) as fully informed as possible on matters relating to the Medical Practice Act under which we function, particularly in the areas of licensure and discipline. Also, any changes in the Medical Practice Act as well as related federal or state legislation will be subjects for further articles. When possible and appropriate, "guidance" on matters of concern regarding the Medical Practice Act will be attempted, appreciating our legal directives in the area of confidentiality.

Capsule portraits of Board members as well as staff will be offered in the hope of familiarizing you to the personnel and personalities of the Board.

The Board is also ready to explain in person, changes in legislation as it affects your responsibility as licensees. Program directors of medical staffs and other medical societies should contact the Board office at (612) 642-0538 to arrange such a presentation.

With this newsletter and our desire to meet with interested constituency, it is our hope to improve the understanding of all our responsibilities as licensees. Comments and suggestions on how we can better keep you, our licensees, fully informed on those issues are respectfully solicited and welcomed.

Melvin E. Sigel, M.D., President
Minnesota Board of Medical Examiners

1988 LEGISLATIVE AMENDMENTS

Medical Practice Act

The Medical Practice Act (Chapter 147) was amended in the 1988 legislative session and signed into law by Governor Rudy Perpich. The Act was amended in the following areas:

a. Publication of disciplinary measures taken by the Board of Medical Examiners will no longer be required if the action is exclusively based on "reason of illness, drunkenness, use of drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition, including deterioration through aging process or loss of motor skills." This provision also applies to a person "becoming addicted or habituated to a drug or intoxicant."

b. Amends the grounds for disciplinary action in the area of fee-splitting. (See page 3 for a description of the amendments and the Board's plans for seeking your input in the rule writing process.)

c. Amends the grounds for disciplinary action to include the prohibition of "referring a patient to any health care provider . . . for services or tests not medically indicated at time of referral."

d. Hospitals, clinics or other health care institutions have had to report to the Board revocations, suspensions, restrictions or conditions placed on the physician's privilege to practice. The amendment requires each such report to "state in detail the reasons for the action, and identify the specific patient medical records upon which the action was based."

e. Authority was granted to the Board to issue temporary permits to practice physical therapy, under supervision. This provision addresses the gap which exists between date of graduation and the availability of national tests and scores.

With this provision, some of the hardship experienced by new graduates will be minimized.

Continued Page 2

MINNESOTA BOARD OF MEDICAL EXAMINERS

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612-642-0538

Continued from Page 1

f. The Board is authorized to share data with licensing boards of other states without the restrictions of the Minnesota Data Privacy Act. Under separate cover, each person licensed or registered by the Board of Medical Examiners will receive a copy of the Medical Practice Act, 1988.

Physical Therapy Act

The law which governs physical therapists (MN Statutes 1986, Chapter 148.70) was amended as follows:

a. Continuing education requirements are authorized in the law. Rules to implement this new requirement will be drafted. Watch for public notices on this activity.

b. The grounds for discipline have been amended with additions in the following areas:

1. A physical therapist may treat a patient for an initial 30-day period without a referral from a person licensed to practice medicine, chiropractic, podiatry or dentistry.
2. Treating a patient without referral, without having first practiced one year under physician's orders is prohibited.
3. Failure to consult with patients health care provider who prescribed physical therapy, if treatment is altered by P.T., is grounds for disciplinary action.
4. Engaging in incentive payment arrangements that tend to promote physical therapy over-utilization is prohibited.
5. Failing to refer a patient to a health care professional whose medical conditions is beyond the scope of practice of the P.T. is grounds for disciplinary action.
6. Failure to report other registered P.T.s who are in violation of the P.T. Practice Act is also grounds for disciplinary action.

Access to Medical Records

Minnesota Statute §144.335 permits a patient to obtain access to his/her medical records or a summary of the records. This amendment requires a provider to furnish the entire medical record to the patient unless the patient consented to receipt of a summary. The statute also allows the provider to exclude from the health record any written speculations about the patient's health condition.

Pharmacy Practices Act

The amendment to section 151.15 which makes it "unlawful for any person other than a licensed practitioner or a pharmacist to compound or dispense legend drugs" appears to preclude a physician from "delegating" this function to an employee.

The amendment also allows the Board of Pharmacy to inspect a physician's practice if the physician engages in the "dispensing, sale or distribution of drugs."

PUBLIC FORUMS TO RECEIVE COMMENTS FOR PROPOSED RULES ON FEE SPLITTING

The 1988 Legislature amended the Minnesota Medical Practice Act (Minnesota Statutes §147) by recasting the grounds for disciplinary action relating to fee-splitting. Prior to these changes, fee-splitting was simply prohibited. Given the financial complexity of the health care delivery system, a simple prohibition did not adequately address the problems faced by practitioners or the consuming public.

The 1988 amendments set forth the broad policy of the State of Minnesota, but leaves the detailed implementation to administrative rules. The Board of Medical Examiners intends to carry out that delegated responsibility by writing and promulgating rules.

The first step in that process is to "solicit information from non-agency sources" regarding the content of such a rule. Simply stated, the Board will seek your advice and opinion on the content for the proposed rule, as well as that of the public.

To facilitate the receipt of your comments and suggestions, four public forums will be held around the state. Listed below are the dates, times and places of the forums. The Board seeks your advice before rule drafting begins. The text of the new statutory language is printed here for your convenience. No reservation is needed for the forums. Please come!

Fee-splitting forums

Wednesday, July 13
Mankato 7:30 PM in the Commons of Mankato East Jr./Sr. High School. 2600 Hoffman Road, Mankato, MN 56001.

Monday, July 18
Duluth 7:30 PM at St. Mary's Hospital. 407 East Third Street, Duluth, MN 55805.

Wednesday, July 20
Detroit Lakes 7:30 PM in the Cormorant Room of Holiday Inn. Highway 10 East, Detroit Lakes, MN 56501.

Wednesday, July 27
Minneapolis 7:30 PM in the Pillsbury Auditorium of Hennepin County Medical Center. 701 Park Avenue, South Building, Minneapolis, MN 55415.

New statutory fee splitting language

147.091 Grounds for Disciplinary Action

Fee splitting, including without limitations:

a. paying, offering to pay, receiving or agreeing to receive a commission, rebate or remuneration, directly or indirectly, primarily for the referral of patients or the prescription of drugs or devices;

b. dividing fees with another physician or a professional corporation, unless the division is in proportion to the services provided and the responsibility assumed by each professional and the physician has disclosed the terms of the division.

c. referring a patient to any health care provider as defined in section 144.335 in which the referring physician has a significant financial interest unless the physician has disclosed the physician's own financial interest; and

d. dispensing for profit any drug or device, unless the physician has disclosed the physician's own profit interest. The physician must make the disclosures required in this clause in advance and in writing to the patient and must include in the disclosure a statement that the patient is free to choose a different health care provider. This clause does not apply to the distribution of revenues from a partnership, group practice, nonprofit corporation, or professional corporation to its partners, shareholders, members, or employees if the revenues consist only of fees for services performed by the physician or under a physician's direct supervision, or to the division or distribution of prepaid or capitated health care premiums, or fee-for-service withhold amounts paid under contracts established under other state law.

BOARD NEWS

Melvin E. Sigel, M.D., Minneapolis, was elected to the Board of Directors of the Federation of State Medical Boards of the United States. Upon his election to the Board, the President of the Federation appointed Dr. Sigel to chair the Legal and Legislative Committee. The Federation is composed of State Boards which license physicians, surgeons and osteopaths and administers the Flex and Spex Examinations.

Richard B. Tompkins, M.D., Rochester, was elected to the Nominating Committee of the Federation of State Medical Boards.

MAY BOARD MEETING HIGHLIGHTS

242 Applications to become licensed to practice medicine in Minnesota were approved.

16 Applications to become registered to practice physical therapy in Minnesota were approved.

10 Applications to become registered as Physician Assistants in Minnesota were approved.

3 Disciplinary orders were issued to restrict persons licensed to practice medicine.

2 Physicians had their licenses restored.

2 Physicians had their previous disciplinary orders modified.

1 Contested case hearing was held.

1 Physical therapist had their license restricted.

The Board also authorized:

Publishing of a newsletter.

Solicitation of comments for proposed rule making.

Response to proposed Federal rules to govern the National Data Bank for adverse information on physicians and health care practitioners.

COMING EVENTS

Minnesota Board of Medical Examiners Meeting

Saturday, July 9
9:00 AM Executive Session (Disciplinary Actions) at Figers Inn, Duluth. 10:30 AM Public Portion (time estimated, immediately following Executive Session).

Fee splitting forums

Wednesday, July 13	*Mankato*
Monday, July 18	*Duluth*
Wednesday, July 20	*Detroit Lakes*
Wednesday, July 27	*Minneapolis*

See Page 3 for details

Continued from Page 3

H. Leonard Boche, Falcon Heights, was named Executive Director of the Minnesota Board of Medical Examiners at its March meeting. He succeeds David Ziegenhagen who resigned in January to become Executive Vice-President, Foundation for Health Care Evaluation.

Boche is available to professional and community groups interested in the role and functions of the Board of Medical Examiners. He can be scheduled by calling the Board at (612) 642-0538.

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FEE SPLITTING: AN OVERVIEW

The 1988 Legislature amended the Minnesota Medical Practices Act (MN Statute §147) by recasting the grounds for disciplinary action related to fee splitting by physicians. The new statutory fee splitting language reads as follows:

147.091 GROUNDS FOR DISCIPLINARY ACTION

Subdivision 1. The board may refuse to grant a license or may impose disciplinary action as described in section 147.141 against a physician. The following conduct is prohibited and is grounds for disciplinary action.

(p) Fee splitting, including without limitation:

(1) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate, or remuneration, directly or indirectly, primarily for the referral of patients or the prescription of drugs or devices;

(2) dividing fees with another physician or a professional corporation, unless the division is in proportion to the services provided and the responsibility assumed by each professional and the physician has disclosed the terms of the division;

(3) referring a patient to any health care provider as defined in section 144.335 (This includes Chiropractors, Dentists, Osteopaths, Pharmacists, Physicians, Podiatrists, Surgeons and Nursing Homes.) in which the referring physician has a significant financial interest unless the physician has disclosed the physician's own financial interest; and

(4) dispensing for profit any drug or device, unless the physician has disclosed the physician's own profit interest. The physician must make the disclosures required in this clause in advance and in writing to the patient and must include in the disclosure a statement that the patient is free to choose a different health care provider. This clause does not apply to the distribution of revenues from a partnership, group practice, nonprofit corporation, or professional corporation to its partners, shareholders, members, or employees if the revenues consist only of fees for services performed by the physician or under a physician's direct supervision, or to the division or distribution of prepaid or capitated health care premiums, or fee-for-service withhold amounts paid under contracts established under other state law.

(OVER)

AN EQUAL OPPORTUNITY EMPLOYER

Some of the more common questions and concerns which have arisen about the new fee splitting law include:

(1) What should be the threshold level for defining the term "primarily for the referral of patients"? (Subsection 1)

(2) How should the term "devices" be defined in the rule? Is it equipment? Ace bandages? (Subsection 1)

(3) What type(s) of written disclosures should be required by the rules? Will a sign in the office or notice on a prescription pad suffice? Are affiliated providers included in the disclosure requirement? (Subsections 2-4)

(4) Should contract disclosure be required by the rules? (Such as disclosure of "terms of division", "physician's own financial interest", or physician's own profit interest".)(Subsections 2-4)

(5) What should be the percentage threshold for disclosing a "significant financial interest"? (Subsection 3)

(6) Should certain types of investments or financial programs be considered automatic grounds for disciplinary action? (Subsection 3 & 4)

(7) How should the term "Dispensing for profit" be defined in the rules? (Subsection 4)

The Board welcomes your comments regarding these above questions and asks you to raise any other questions or concerns you may have regarding the fee splitting rules.

We invite you to submit written comments on the fee splitting rules. All written statements should be addressed to:

Minnesota Board of Medical Examiners
2700 University Avenue West, Suite 106
St. Paul, MN 55114-1080

Any written materials received by the Minnesota Board of Medical Examiners shall become part of the rulemaking record to be submitted to the attorney general or administrative law judge in the event the rule is adopted.

Oral statements will be received during regular business hours over the telephone at (612)642-0538 and in person at the above address.